THE CANADIAN NURSE

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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1522 Sherbrooke Street West, Montreal 25, Quebec

Between Ourselves

Last May when the throng of nurses assembled in Philadelphia for the convention of the National League for Nursing, several Canadian nurses joined with their American colleagues for the week's sessions. JEAN E. MACGREGOR has given us a running commentary on many aspects of the meetings. JACQUELINE GAGNON, who is on the professional staff of the Association of Nurses of the Province of Quebec has written a longer report on her observations. We are pleased to be able to share the impressions of these two able observers with you. We commend them to you.

* * *

The emphasis in this month's issue is on some of the problems occurring in obstetrics. One of the most controversial issues in this field is the question of the more effective use of highly qualified nurses in the delivery of women with child. In separate articles NORAH E. CUNNINGHAM, who received her midwifery training in New York, and ALICE C. MILLS, who holds her certificate from the Central Midwives Board in Britain, point out the flaws in the present pattern so far as Canadian mothers are concerned.

In the popular mind, the term "midwifery" conjures up a picture of a slovenly, ignorant, usually untrained woman who looks after the mothers in her neighborhood who cannot afford or live too far from a doctor. There probably are a few such women in remote areas or in crowded tenement districts of the large cities. Some Canadians of foreign extraction prefer to have a woman of their own race come into the home and take complete charge of the delivery, the housekeeping and the other children.

Despite the fact the law of the land forbids qualified midwives to function, there is recognition of the fact that many women cannot be supervised through the prenatal period and given adequate delivery care by a medical practitioner, much less a qualified obstetrician. Our world-famous Mounties are given a brief training in obstetrics during their preliminary period so that they may assist in an emergency. The University of Alberta School of Nursing provides for graduate nurses a certificate course in "Advanced Practical Obstetrics" — five months of study and supervised clinical experience in the care of the mother and the newborn infant. Is it not time that the nursing profession became actively interested in promoting the legalization and recognition of nurse-midwives?

SISTER STE. MECHTILDE, with long experience in working among these unfortunates, discusses some of the reasons why young women take the misstep that leads to unmarried parenthood. Her greatest stress is placed on the importance of providing the home environment and parent-child relationship that will act as a preventive, restraining influence. When, however, a young unmarried mother comes to our attention as nurses, Sister gives us sage advice as to how best we can help to restore her to a normal, happy life.

* * *

Last June we published the initial draft of the itinerary the CNA tour to Europe would cover. This program has been considerably revised as you may read. This is a wonderful opportunity for nurses to enjoy some new professional experiences at the same time that they are having a marvellous time sightseeing. Be sure you get your passage lined up in ample time!

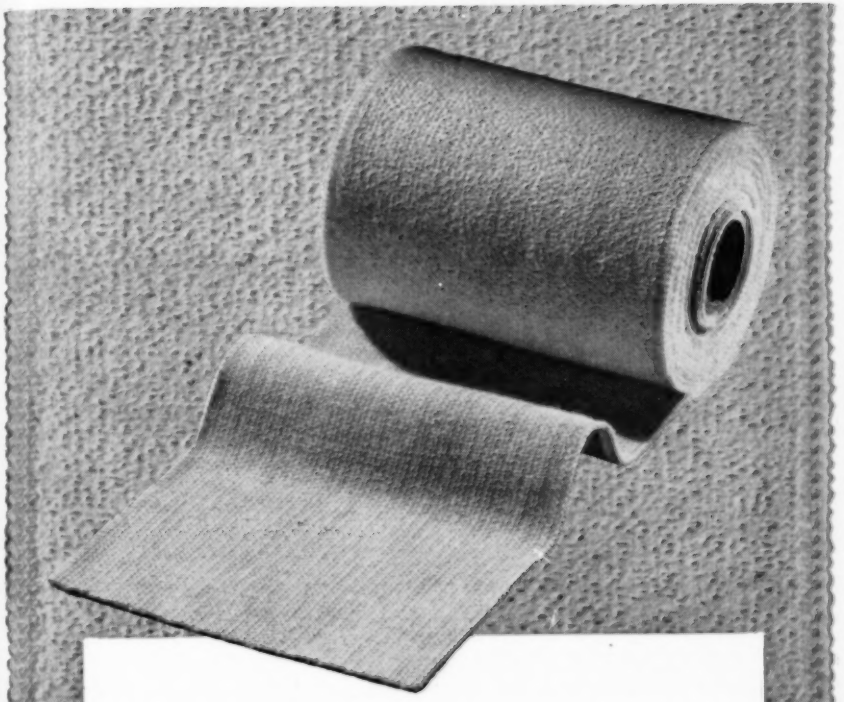
* * *

Who will be the first nurse to register for the 1960 CNA convention in Halifax? Our wager would be placed on either one of two nurses — one resident in British Columbia, the other in Quebec, both of whom always attend. We have no intention of organizing a sweepstake around these possibilities but we do recommend that those of you who have been contemplating attendance at this interesting affair should use the Registration form on page 1011 now. Remember, there is provision for the return of your registration fee if next spring you find that you have to change your plans. Directors of nursing and student organizations should remember, too, that student registrations may be made on the basis of so many persons — it is not necessary to specify the names of students who will be attending, at this early date.

The entire area of the Sahara desert is more than 3,500,000 square miles — about equal to the area of Canada.

Nothing prevents our being natural so much as the desire to appear so.

— LA ROCHEFOUCAULD



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ESIDRIX TABLETS

Indications—All conditions requiring resolution of edema, including congestive heart failure, hepatic edema, renal edema (including nephrosis and certain types of nephritis), edema and toxemia of pregnancy, premenstrual tension, steroid-induced edema and obesity (if fluid retention is a complicating factor). Also of value in all types and degrees of hypertension, either alone or in combination with various antihypertensive agents which it potentiates. It may be safely used in hypertensive vascular disease with or without associated congestive failure.

Administration—To initiate diuresis and saluresis, a single oral dose of 50 to 100 mg. is administered after breakfast. This dose may be repeated after lunch and once or twice daily thereafter until dry weight is attained. Maintenance doses ranging from 25 to 150 mg. daily, either daily or intermittently, may be required to maintain freedom from edema. In hypertension, the average dose for initiating therapy is 75 mg. daily (usually 50 mg. after breakfast and 25 mg. after lunch). When added to the regimen of patients receiving other antihypertensive agents, care must be taken to avoid excessive blood pressure reductions. Dosage must be carefully individualized and, as with any diuretic, patients must be regularly observed for early signs of fluid or electrolyte imbalance and corrective measures initiated should they be indicated.

Description—Hydrochlorothiazide, saluretic and diuretic compound with approximately 10 times the potency of chlorothiazide.

Manufacturer—Ciba Company Ltd., Montreal.

KAFOMA

Indications—Prophylaxis of dental caries and as an organic source of calcium and phosphorus.

Description—Each chocolate-flavored tablet contains: Calcium 100 mg. phosphorus 46 mg., magnesium 0.5 mg., silica 0.03 mg., standardized fluorine content of 0.15 mg. as the organic salt of bone meal.

Manufacturer—Nordic Biochemicals Ltd., Montreal.

NEPTAZANE TABLETS

Indications—In the treatment of glaucoma. Neptazane has been found to be therapeutically effective in 50% of those patients who had failed to respond to Diamox; 50% of the patients who could not tolerate Diamox due to side effects were able to be controlled on Neptazane without side effects. Suggested that Neptazane be considered in those patients who either do not respond to Diamox or who cannot tolerate it.

Administration—The effective therapeutic dosage varies from 50 to 100 mg. 2 to 3 times daily.

Description—Brand of methazolamide, a carbonic anhydrase inhibitor similar to Diamox (acetazolamide) in chemical structure but with certain different pharmacological properties which makes it a companion product to Diamox in the treatment of glaucoma.

Manufacturer—Lederle (Canada), Cyanamid of Canada Limited, Montreal.

OLICIN

Indications—Treatment of common infections caused by staphylococci (including strains resistant to other antibiotics); streptococci (beta-hemolytic strains, alpha-hemolytic strains, and enterococci); pneumococci, gonococci, and hemophilus influenza. Experimental studies have also shown effectiveness against rickettsiae, large viruses and certain protozoa, notably amebae. Particularly for infections of the respiratory and genitourinary systems.

Administration—Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. to 500 mg. 4 times daily. For children 8 months to 8 years of age, a daily dose of approximately 15 mg./lb. body weight in divided doses has been found effective.

Description—Triacetyl ester of Oleandomycin, antibiotic derivative therapeutically stable in gastric acid hence absorbed rapidly to yield higher blood levels than previously attained with other agents of the group.

Manufacturer—Pfizer Canada, Montreal 9.

MUREL

Indications—Gastrointestinal, genitourinary and biliary tract spasm; adjunctive therapy in peptic ulcer.

Administration—For severe spasm, 10 to 20 mg (1 to 2 cc.) intravenously or intramuscularly every 4 to 6 hours up to 60 mg. in 24 hours. For mild to moderate or chronic cases, and for maintenance 1 or 2 tablets 4 times daily.

Description—Valethamate bromide 10 mg. tablets; spasmolytic compound providing anticholinergic, musculotropic and ganglionic blocking action.

Manufacturer—Ayerst, McKenna & Harrison Ltd., Montreal.

The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.

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3. **Diploma Courses for Graduate Nurses**
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   (a) Teaching in Schools of Nursing

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Administration: Wash affected areas thoroughly with mild soap and water. Apply a thin layer of cream once daily and at bedtime.

Description—A flesh-colored, greaseless, fast-drying cream containing superfine sulfur, zinc oxide, resorcinol and hexachlorophene in a cosmetically elegant and superior base.

Manufacturer—Leslie A. Robb, 5 Traymore Crescent, Toronto 9.

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Administration—Apply after each diaper change. Smooth over baby's entire body after bath, making sure to reach folds where moisture may collect and cause irritation.

Description—A superbly smooth, free flowing, pleasantly scented emulsion containing a special liquid lanolin (Lano-Des), hexachlorophene, vitamins A and E, cleansing emulsifiers, wetting agents. Especially formulated for all-over care of the infant's skin.

Manufacturer—Leslie A. Robb, 5 Traymore Crescent, Toronto 9.

KENALOG

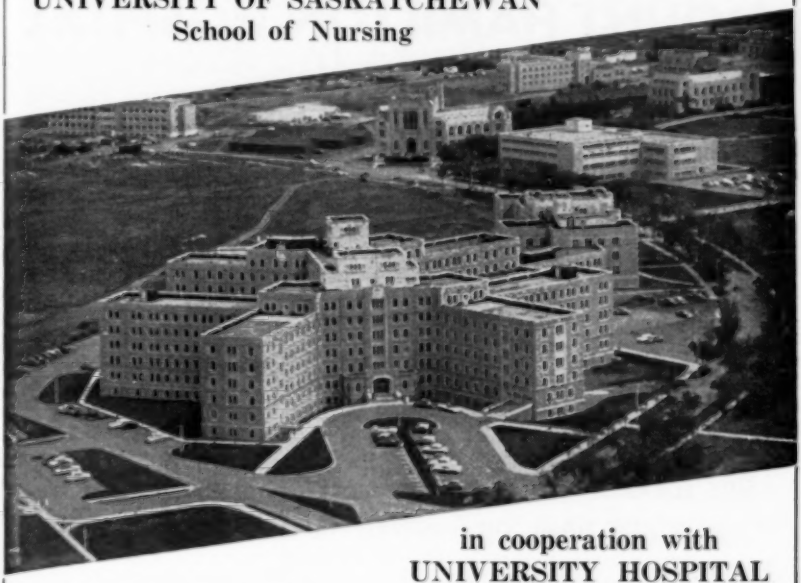
Indications—Many inflammatory skin conditions, including atopic dermatitis, contact dermatitis, eczematous dermatitis, neurodermatitis, seborrheic dermatitis, insect bites, pruritus ani, pruritus vulvae, lichen simplex chronicus, exfoliative dermatitis, stasis dermatitis, nummular eczema.

Administration—Cream or lotion is rubbed into affected area 2 to 3 times a day. Ointment is applied lightly to the affected area 2 to 3 times a day.

Description—Triamcinolone acetonide, (9-alpha-fluoro-16-alpha, 17-alpha-isopropylidene-dioxy-delta-1 hydrocortisone) potent, topical corticosteroid. Often acts faster than hydrocortisone and is frequently effective in those instances where hydrocortisone and other corticosteroids fail to bring about a good or complete therapeutic response.

Manufacturer—E. R. Squibb & Sons of Canada Ltd., 2201 Côte de Liesse Rd., Montreal.

UNIVERSITY OF SASKATCHEWAN
School of Nursing



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Indications—Spastic states of skeletal muscle; as a relaxant in surgical anesthesia.

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Manufacturer—Allen & Hanbury's Company Ltd., Toronto.

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Indications—For use as the sole or main source of nourishment for infants and children with phenylketonuria (or phenylpyruvic oligophrenia) which is due to a congenital inability to metabolize the essential amino acid phenylalanine properly.

If the condition is allowed to progress, brain development is arrested, and severe mental deficiency develops.

Administration—Physician control must be exercised. Should not be fed to normal children.

Description—A balanced low phenylalanine food made from a special casein hydrolysate low in phenylalanine combined with fat (corn oil) and carbohydrate (Dextri-Maltose and arrowroot starch). Vitamins and minerals are included to provide amounts similar to those in the usual milk formulas.

Manufacturer—Mead Johnson of Canada Ltd., 5757 Decelles Ave., Montreal.

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Indications—Experience to date indicates the activity of griseofulvin is confined to the dermatophytes, which are responsible for the superficial mycoses, tinea pedis, scruris, corporis and capitis. In particular Grisovin has produced good results in Trichophyton rubrum infections even in cases of many years duration.

Administration—1 gram (4 tablets) daily by mouth. In more severe or extensive cases up to 2 grams daily may be given to adults at the beginning of treatment, reducing to 1 gram when clinical response has occurred.

For children doses of 250 to 500 mg. daily, but as much as 1 gram daily has been given without side effects.

Description—Scored tablets containing 250 mg. Griseofulvin, orally active antibiotic for treatment of fungal infections of the skin.

Manufacturer—Glaxo (Canada) Ltd., Toronto.

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For additional information, write to:

School of Nursing,
McMaster University, Hamilton, Ontario.

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282 MEP

Indications—Pain accompanied by muscle spasm and anxiety, as in tension headache, low back pain, menstrual stress, bursitis, arthritis, postoperative pain, cancer.
Administration—One or two tablets every 4 to 6 hours as required.
Description—Each tablet contains: Acetophen (acetylsalicylic acid) 200 mg., phenacetin 150 mg., caffeine citrate 30 mg., codeine phosphate 15 mg., meprobamate 200 mg.
Manufacturer—Charles E. Frosst & Co., Montreal.

PENTRAX

Indications—For preventive management of angina pectoris, coronary insufficiency, and coronary artery disease, particularly when aggravated by tension or anxiety.
Contraindications—Should be used cautiously in glaucoma.
Administration—Should be taken before meals and on a continuous dosage schedule. It does not take the place of nitroglycerin in treatment of the acute attack. Begin therapy with 1 to 2 yellow tablets 3 to 4 times daily. This may be increased for maximal effect by changing to pink tablets.
Description—Pentrax 10 — Yellow tablets: PETN (pentaerythritol tetranitrate) 10 mg., Atarax (hydroxyzine) 10 mg.
Pentrax 20 — Pink tablets: PETN 20 mg., Atarax 10 mg.
Manufacturer—Pfizer Canada, 5330 Royalmount Ave., Montreal.

SINUTAB

Indications—Sinus headache.
Administration—Adults, at first symptoms, 2 tablets followed by one every 4 hours. **Children** (6 to 12 years), one-half adult dosage.
Description—Each tablet contains: N-acetyl-p-aminophenol 150 mg., phenacetin 150 mg., phenylpropanolamine HCl 25 mg. Phenyltoloxamine dihydrogen citrate 22 mg.
Manufacturer—Warner-Chilcott Laboratories Co. Ltd., Toronto.

STERI/SOL

Indications—Bacterial and fungal infections of the mouth and throat.
Administration—Apply by swab to local lesions; for buccal and pharyngeal lesions, swish in mouth and gargle for 30 seconds, using 15 cc. morning and night.
Description—Hexetidine (bis-1, 3-beta-ethyl-hexyl-5 methyl - 5-amino hexahydropyrimidine solution, a broad-spectrum bactericide and fungicide for topical application.
Manufacturer—Warner-Chilcott Laboratories Co. Ltd., Toronto.

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SUPT. OF NURSES, NOVA SCOTIA SANATORIUM, KENTVILLE, N.S.

Random Comments

Dear Editor:

May I comment on the general quality of our magazine? "It gets better all the time!"

G. L., Ontario

Dear Editor:

I enjoy the magazine so much, especially the way you handle articles on specific ailments. The series on heart catheterization was excellent. I even read the one in the research section!

J. M. S., Ontario

Dear Editor:

At present I am not in active nursing so my copies of *The Canadian Nurse* keep me abreast of the times. I have kept every issue since I started my training in 1950 and really enjoy running through my file.

B. C., Saskatchewan

Dear Editor:

I want to tell you how very much I appreciate and enjoy my copies of our journal that reach me regularly here in Africa. Not only am I aware of the marvellous new discoveries made in medicine and the advances in nursing but I feel so much less isolated for it keeps me in touch with the rest of the nursing world.

E. A., West Africa

Dear Editor:

You recently printed a letter that expressed disapproval of young graduates going "to rural areas, to the northland." I have lived and worked in this small northern community for several years. We have a nice hospital here, quite modern as to building and equipment, and the variety of nursing experience is unlimited. Our work has expanded so much that we need more nurses, more nursing assistants.

Incidently, there are many bachelors in the northland! I met my husband here.

A. I., Ontario

Dear Editor:

I look forward each month to the arrival of *The Canadian Nurse* and so, I may add, do my English colleagues! We particularly enjoy the numerous case histories which are so much more concerned with nursing care than many similar reports that are published over here.

I always turn first to the Nursing Profiles where I can occasionally read of friends and often of acquaintances.

A. G. N., England

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   Classes — September and February.

   (b) Two month clinical course in Gynecological Nursing.

   Classes following the six month course in Obstetrical Nursing.

   (c) Eight week course in Care of the Premature Infant.

---

2. Six month course in Operating Room Technique and Management.

   Classes — September and March.

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3. Six month course in Theory and Practice in Psychiatric Nursing.

   Classes — September and March.

Complete maintenance or living-out allowance is provided for the full course.

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Experiences include cancer research, Chemotherapy, medicine, surgery, and radiation therapy. A monthly stipend, laundry, and two meals a day are provided. Students are assisted in securing desirable living facilities.

Classes are admitted in the Fall and Spring semesters. Applications for February 1960 should be filed no later than November 30, 1959.

For further information write to:

NORMA F. OWENS, DIRECTOR INTERNSHIP IN ONCOLOGICAL NURSING, DEPT. OF NURSE EDUCATION, SCHOOL OF EDUCATION, NEW YORK UNIVERSITY, WASHINGTON SQUARE, NEW YORK 3.

Dear Editor:

I wish to extend my sincere congratulations to the Association of Nurses of the Province of Quebec for endorsing *L'Infirmière Canadienne* and to the Canadian Nurses' Association for making this publication a reality. Please send me the French copy from now on instead of the English.

A great many nurses here will benefit by the new *Journal* for rarely do you find one who can read English. *L'Infirmière Canadienne* will be of wonderful service in thus presenting such a high standard of work. It will be accepted with joy in an underdeveloped country such as this where French is the second official language.

S. S-M., Vietnam

Manitoulin Island in Lake Huron is the largest fresh water island in the world. It is nearly a hundred miles in length, from two to forty miles wide.

* * *

Over 9 million Canadians are served by federated appeals in 99 cities.

— The Canadian Welfare Council.

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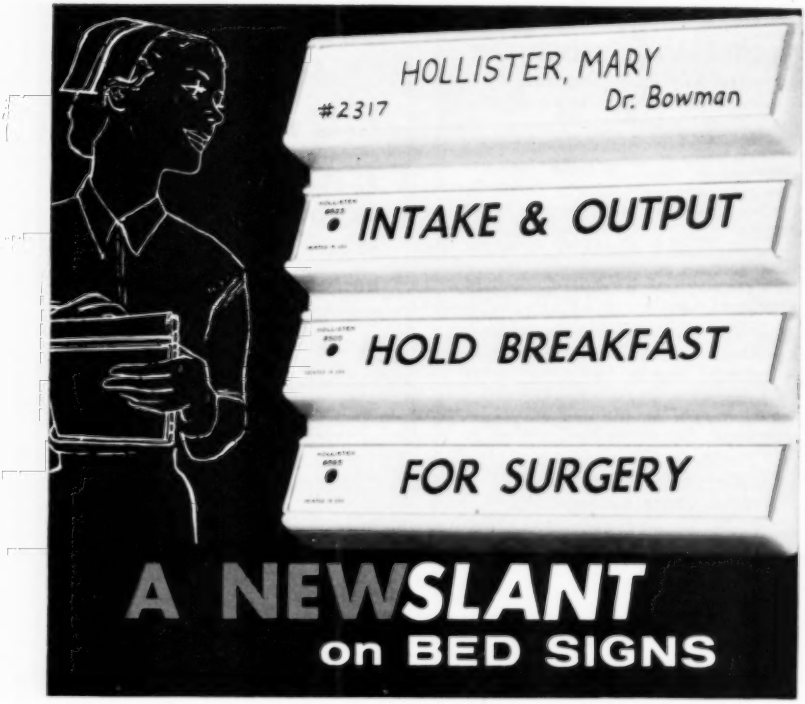

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Visiting Our Neighbors

PHILADELPHIA, PA. — City of Brotherly Love — was convention headquarters for delegates to the National League for Nursing biennial meeting May 11-15, 1959. Immediately prior to this the National Student Nurses' Association convention was held; the NLN board of directors, special committees and other groups met. To provide seating space for those expected to attend the general sessions, Convention Auditorium just across the street from Philadelphia General Hospital — the "Old Blockley" of earlier days — was used. Just around the corner was the University of Pennsylvania Museum with its exhibit of Nightingaliana. This was the setting for the all-time high registration of 4,285 delegates.

On the ground floor, 632 exhibitors' representatives were busy from early morning until late afternoon explaining, demonstrating, distributing samples, providing information. One of the busiest booths was the large one manned by the various members of the National League for Nursing staff. Nurses dropped by to ask about scholarships, to inquire about postgraduate programs. The *Nursing Outlook* booth had a steady stream of customers looking for their daily copy of the news bulletin, *Convention Outlook*, or ordering full sets to be sent home or to friends. The publication of the convention newspaper is a much appreciated service and delegates particularly treasure the issues listing the names and hotels of all registrants. A quick and easy way to find your friends!

As a Canadian visitor, there were certain impressions that tended to remain uppermost in one's mind. One of the first was produced through sheer force of numbers. The impact of having several thousands of nurses suddenly converge on one spot on the map affected not only the city itself but apparently the transportation facilities. The train porter, who stopped to chat briefly, obviously did not expect to be contradicted when he said "You are a nurse." The helpful policeman gave directions about streets and buses and added the symptoms of his head cold. Special displays in libraries and stores plus a huge bill-board greeted the delegates.

The growth in size and power of

the National Student Nurses' Association was equally impressive. Formed in 1952, the NSNA numbered 77,500 members at the end of 1958. Almost 3000 students attended this year's convention and some remained over to be present at the NLN sessions. These young women are receiving excellent preparation for future professional responsibilities.

The licensed practical nurse has very obviously attained a respected position on the nursing team. The Council on Practical Nursing stressed the "dynamic role" taken by the L.P.N. in relieving the nurse shortage. Discussions of the Council included the necessity for providing sound educational programs in practical nursing; the advisability of providing home nursing experience; the possible inclusion of mental health nursing in the basic programs for practical nurses. The most important decision reached for this group was the acceptance of the resolution requesting accreditation of schools of practical nursing by the National League for Nursing.

A constant concern at convention-time is to find the most interest-holding method of presenting information. The Department of Public Health Nursing drew a packed house for "3 Maple Street" — a play produced by the American Theatre Wing, with a cast of professional actors. The portrayal emphasized the fact that public health nursing is a family affair. It was a most successful venture and provided one of the main highlights of the entire convention.

The program planners had also arranged for a very extensive showing of films. The subjects thus covered touched upon a very wide variety of situations either in nursing or related to it. Each session drew a good representation of delegates. It was an excellent opportunity to see the films and to evaluate their possible use.

Many other aspects of these convention sessions could be mentioned but two final glimpses must suffice. The presentation of the Mary Adelaide Nutting Award to Miss Effie Taylor "for outstanding leadership and achievement in nursing" provided a touching few moments during the Keynote session. Miss Taylor, who was president of the International Council of Nurses for 10 years, was a member of the last class that Miss Nutting graduated from Johns Hopkins Hospital school of nursing. In her acceptance speech, Miss Taylor took her audience back to that day over 50 years before when a timid young probationer had her first meeting with one of the great ladies of nursing — and decided that maybe she really would like nursing after all.

And finally, there was the convention dinner in the beautiful Grand Ballroom of the Sheraton Hotel. The speaker for that evening was William J. Bishop, librarian and medical historian, London, England. For the past five years he has been engaged in an intensive study of the published writings of Miss Nightingale and has now almost completed the Nightingale Bibliography. It has meant, among other tasks, reading and cataloguing more than 12,000 letters. As a result, Mr. Bishop has an unequalled understanding of this remarkable woman, and his admiration for her was very evident. He spoke of her message for modern nurses and nursing, and his closing remarks give us the essence of this message.

"She had always seen to the heart of things — that the sick person must be treated and not the disease, that prevention is infinitely better than cure, that universal hospitalization will not give positive health or 'wholeness', and that nursing must hold to its ideals but must change some of its methods."

JEAN E. MACGREGOR

That reliable standby, the potato, was discovered by the Spaniards after the conquest of Peru early in the 16th century. They took it to Europe where its use as a staple dietary item for poor families reduced threats of starvation when grain crops failed. It was introduced into Canada in 1763.

Responsibility's like a string we can only see the middle of. Both ends are out of sight. — WILLIAM MCFEE

* * *

A man is not idle because he is absorbed in thought. There is a visible labor and there is an invisible labor. — VICTOR HUGO

In Step with Modern Progress

JACQUELINE GAGNON, B.S.N., M.S.S.

WE live in an era of change and invention against which it would be very stupid of us to rebel. In a country where techniques have reached a level far in excess of early estimates, it is not surprising to discover that everyone engaged in nursing is anxious to keep in step with the latest in scientific progress.

The theme of the 1959 National League for Nursing convention, "Nursing for a Growing Nation," could be expressed even more precisely in the words of the title of this report for the same thread ran through all of the sessions. A listing of all the papers presented would read like a catalogue and would not be particularly useful to the readers of this *Journal*. I shall content myself with a discussion of four aspects of nursing that received marked attention, not only because of their own importance but also because they were presented by outstanding persons. These four points are:

a. education

b. hospital and school of nursing administration

c. public health and other nursing specialties

d. research in nursing

Education

The opening address was presented by Norman Cousins, editor of *Saturday Review*. He underlined emphatically that the greatest need of any nation is to ensure that all of its citizens may take full advantage of available educational opportunities.

> It is not enough to increase the number of schools. It is necessary, above everything else, to provide the kind of education that will be of benefit to the citizen of tomorrow — this citizen who is obliged to live in a world where unreasonable demands that are made on each individual are more pressing and more numerous than they have been ever before. It is equally necessary that our schools should provide such an education as will prepare people to adjust fully to the environment in which they find themselves.

Miss Marie Farrell, professor of education at Boston University emphasized the fundamental importance of a broad basic preparation for the nurse who wishes to secure advanced professional education. This requirement is essential since these nurses frequently are called upon to assume responsibility for the training of other nurses. If the teachers do not have well-balanced and flexible minds, if they do not enjoy reading, have a love of books, the capacity to evaluate their teaching methods periodically, to review the programs annually in order to keep them as up to date as possible, it is very obvious that they would be incapable of passing on the basic professional education that is absolutely essential for present-day nurses.

In his address, the president of Western Reserve University pointed out that nursing should be truly considered as a profession. The program that is essential to reach that point

JACQUELINE GAGNON

Miss Gagnon is assistant secretary of the Association of Nurses of the Province of Quebec.

is based on a solid liberal education. Nursing is presently at the crossroads and the direction it takes will depend upon the quality of leadership and the preparation for their tasks that each nurse has. Nursing education should prepare people who have professional awareness and the will to raise the standards of the profession. Every nurse who occupies a key position in nursing should hold at least a certificate as evidence of postgraduate study. The opportunities for such study have been available ever since the first university program was established at Teachers College, Columbia University in 1899. That school still offers a wide variety of programs to meet all the various specialties in nursing.

Over and over again, when the question of specialization came up the speakers and panelists alike emphasized the absolute necessity of a sound preliminary preparation, on good basic education. Dr. Lulu Hassenplug, dean of the school of nursing of the University of California went so far as to declare that we have not been careful enough in examining the persons admitted to our profession. She thought that we have too much dead wood, too many poorly oriented nurses who do not possess the indispensable qualities that lead to success in this field.

Administration

Three specialists presented papers on the question of administration in hospitals and in the school of nursing. Dr. Hans O. Mauksch, of Chicago, noted that the nursing team, while it has a responsibility for a group of patients, does not necessarily reflect the organization and administration of the hospital. Mr. Solomon Gladstein described an experiment at Sinai Hospital, Baltimore where the nursing team and the administration team were organized separately, both being under the direction of the head nurse. He noted also that the team composed of the ancillary workers is under the supervision of a competent staff member, thus relieving the head nurse. The latter can then devote all her time to the well-being of the patients without having to spend precious hours counting pillows or kitchen utensils.

Miss Ruth A. Preston of Johns Hopkins Hospital painted a word picture of the ideal organization of nursing service. She analyzed the functions of everyone concerned directly or indirectly with nursing. On the basis of her analysis she proposed a new distribution of duties, relegating all of those functions not strictly related to nursing to auxiliary personnel.

A well-organized hospital ought to have on its staff a nursing educator who would have the title of consultant. Her role would be to analyze and evaluate the services, to suggest new approaches to problems and to recommend changes when necessary. This specialist, besides being an authority in her own field, should be able to present new ideas and techniques acceptably to the people who have the final responsibility for making decisions. The good administrator requires an orderly mind and a sense of values. Administration is a *means to an end* and not an end in itself. The end is to provide the best possible care for patients; the administrative staff should concentrate on achieving that goal.

Public Health and other Nursing Specialists

Miss Marion W. Sheehan of the National League for Nursing recalled two essential aims that nurses should not lose sight of in the exercise of their profession: to endeavor to secure the maximum health possible for individuals and their families; to provide the essential services in the least costly fashion, striving for efficiency and avoiding duplications that are costly and often useless. Five areas were considered to be of primary importance to nurses engaged in public health nursing:

1. *Maternal and infant welfare*:

In the development of public health there has been a trend to establish prenatal clinics where pregnant women could receive advice and appropriate care. It has been suggested that the nurse as well as the doctor should remind the mother that she is not ill, that she has a responsibility to her unborn infant to keep herself well and that she should accept all the help that is offered. This supervision does not stop with the birth of her baby. Throughout infancy and the preschool period the nurse will help to solve health problems of the child, both physical and mental.

2. *Child hygiene and adolescence*:

The nurse who sees the children during her school visits would find it a distinct advantage to have a sound understanding of child psychology.

3. *Mental Hygiene*:

Fully appreciating the important place that psychiatry occupies in modern treatment, it serves to emphasize the value of every nurse receiving sound preparation in this field.

4. *Tuberculosis*:

The nurse has a distinct contribution to make in the rehabilitation of these patients — not only through the care she gives but also through her moral support and optimism. She is one of the most valuable members of the team that is working toward the return of these patients to normal living.

5. *Public health and the hospital*:

Dr. Herbert Lewis of Yale University described the public health clinic established in a hospital in New Haven. This clinic was established to supervise the well-being of all the hospital personnel. The public health nurse attached to this service is expected to know each employee, the state of his health, his behavior on duty and the factors that affect his efficiency. So successful has this program been it is enthusiastically recommended as a pattern for all hospitals.

Research in Nursing

The problem of research brought together an imposing number of nurses. After considerable discussion, they were agreed that since nursing touches on so many other very active and dynamic disciplines there is a risk of our profession becoming stagnant if it is not constantly revivified by research. Three pieces of research, in particular, were presented. While none of them was designed to bring in a utopia, each could be regarded as a guide to better practices in nursing.

The first study, under the direction of a psychologist looked into the question of relations between the patient, the nurse, the doctor and the members of the family during the recovery period. The second presentation considered the nursing care given a patient with acute stomatitis. The provision of the best nursing care for premature infants was the basis of the third report.

Conclusion

This report, despite its length, scarcely pays full justice to all the valuable addresses that were presented. One of the most interesting was given by William J. Bishop, librarian and writer from London, who has nearly completed the enormous task of cataloguing the writings of Florence Nightingale, including her letters.

I cannot close without sharing some strictly personal thoughts with you. Perhaps there is a tendency to exaggerate the importance of the nurse having a broad background of knowledge in such related fields as psychology or sociology. On the other hand, is it not enough for her to be conversant with the lines of thought in these different disciplines, free to make use of the good offices of these specialists when there is need?

I believe it would be useful to note that the problems of nursing are the same in the United States as in Canada. If we wish nursing to be truly professional, it is important to be very careful in the choice of candidates because the nurse is being called upon more and more to occupy positions of exacting responsibility that demand a sound basic training and broad postgraduate studies.

One final word! I have been much impressed by the financial assistance that is available for nursing education in the United States. This assistance comes not only from the individual states but also from the federal government and from foundations. All of these substantial grants make it much easier for specialists to become qualified, for the services to be expanded for research projects to be undertaken. I wish that our public administrators and business leaders could become more interested in the problem of finding ways and means of preventing illness and safeguarding health.

A wise scepticism is the first attribute of a good critic.

— James Russell Lowell

Life is a wave which in no two consecutive moments of its existence is composed of the same particles. — John Tyndall

Supportive Maternal and Child Care

NORAH E. CUNNINGHAM, M.A.

SUPPORTIVE maternal and child care is that care given to the mother, the baby, and the father too, during the obstetrical experience starting early in pregnancy — there is some thought that such care should begin before pregnancy. It should continue from as early a period as possible throughout the pregnancy, through the postpartum period, into the early adjustment of the family. Supportive care provides physical, instructional, and emotional care. These aspects are intertwined and interdependent.

Physical Care

Medical science is giving a great deal of thought and attention to the subtle causes of defect and death in the field of maternal and child care. We read of problems of neonatal and perinatal mortality, of congenital defects. Dr. Anderson, a researcher in this field at Johns Hopkins Hospital,[1] uses the term "reproductive wastage" within which he includes not only the perinatal mortality, stillbirths, fetal wastage but also congenital defects or malformations compatible with life such as cerebral palsy, blindness, deafness, mental retardation. In this way he groups together not only infant deaths but children who will continue to be problems as they grow out of infancy. Dr. Anderson feels by bringing together data on the total picture of reproductive wastage a better perspective of the enormity of the problem is realized. In Ontario a study involving the large teaching hospitals is trying to come closer to the causes behind such wastage of life.

In the maternal health field there has been tremendous progress in giving improved physical care but there are still many women who appear to have a high pregnancy risk. The causes behind miscarriages, stillbirths and toxemia are not fully understood. The problem of nutrition in pregnancy has not been fully explored.

A collection of facts about the physical care of the mother and infant is needed as a basis for discovering causes and preventing the present amount of defect and death. The studies, research and action will cut across many disciplines — obstetrics, pediatrics, endocrinology, psychology, chemistry, as well as public health and hospital services.

Dr. Anderson uses another term "cooperative understanding," in describing the needs in the field of reproductive wastage. This is a good phrase to keep in mind as we try to improve maternal and child care.

Another problem in providing good physical care is the need for continuity. Dr. Wilson G. Smillie, former professor of preventive medicine at Cornell University, states that this need for continuity is the outstanding one in medical care today. For example, a pregnant woman may deal with a public health nurse, several clinic nurses and a clinic doctor; in labor and delivery she meets other nurses, doctors; in postpartum with the postpartum nurse, and the nursery nurse. Even if each nurse, doctor and allied worker is trained and desirous of giving the best of care it is felt that the total care is weakened by segmentation — that there is little integration because of lack of coordination or follow through. There is lack of communication between co-workers so care suffers. The patient is confused and consideration of many of her needs is lost.

Hazel Corbin[2], Director of Maternity Center Association, New York, says,

> We have reaped the many benefits of specialization. Now the time has come for communication, interpretation and integration for an interdisciplinary program designed not only to insure healthy mothers and babies but also to help parents achieve a happy home life and warm secure relationships.

Here are more key words to remember — communication, interpretation, and integration.

In maternal and child care we are

Miss Cunningham is regional supervisor of maternal and child health with the Department of Public Health Nursing for Ontario.

realizing that the goals of hospital and public health services are similar — perhaps closer together than care in other fields. Both are dealing with the normal process of birth — the healthy family, the healthy mother, the healthy baby. The too-common argument used in the past, that public health deals with the more or less well person and the hospital with the sick, does not apply in maternal and child care. It is perhaps easier in this area for us to realize the need of "cooperative understanding." Demonstrations of "communication, interpretation and integration" here will be helpful in pointing ways in other areas for much needed cooperation between public health and hospital.

Standards of care in maternal and child health services are receiving increasing attention in Canada. We are trying first to find out what conditions actually are. Manitoba is at work in this problem. Ontario has started with an assessment of premature care. We must look objectively at what we are doing. Principles as far as basic care and safety in obstetrical services should apply anywhere — in small centers as well as large. In some rural areas there are hospitals where the nearest blood bank is over 50 miles away, with no laboratory facilities, and with very limited facilities for premature care. There are the problems of costs but minimum standards of care should be maintained wherever service is given to the pregnant woman and wherever a child is born.

Dr. Jean F. Webb[3], chief of Child and Maternal Division, Department of National Health and Welfare has written:

> There are indications in some parts of our country in terms of excessive maternal, neonatal and stillbirth rates that all women are not receiving adequate care. An objective study of maternity care in some of these areas would be very interesting in evaluating the relative importance of economic factors, the availability of services and of the mother's own attitude toward her need for medical and nursing care during pregnancy.

A first step toward setting standards is seen in the Guide for Study of Maternity and Newborn Nursing Service[4], prepared by Dr. Webb's department. This is interesting and useful because it outlines a plan for the survey of all public health and hospital services for prenatal, delivery, postnatal and baby care in a community.

Instructional Care

It is difficult if not impossible to entirely separate this from physical or emotional care, but let us try to do it. We know there are increased demands from parents for knowledge of child rearing — of how their babies are born, develop and should be cared for. Parents' classes have become increasingly popular. Consider the matter of natural childbirth. There is a great need for parents to understand and be guided to a sensible realistic viewpoint. Many articles have appeared in the popular magazines. Many of these lead me to wonder if too often parents feel doctors, nurses and hospitals are working against them. Certainly in this area there is a need for cooperative understanding, communication, interpretation, and integration. Nurses should listen carefully to parents' questions and plan their teaching to meet these demands for education.

Emotional Aspects

There is a trend to a more encompassing meaning of health — to tie in mental and emotional health with the physical. We use the term "the whole person," thus we must consider the individual's mental attitudes, the social, economic, racial and family background as being important to medical care and health promotion.

Life is made up of stresses. Pregnancy is one of these that may be complicated by the woman's fear of the unknown, her attitude to the pregnancy as an illness, and a fear of the hospital. Dr. Hans Selye[5] has given us greater understanding of these problems. We are gradually realizing the part that stress can play in sapping physical strength and nurses are becoming increasingly aware that they take a part in lessening or at least not adding to stress as they deal with persons under their care.

We know of the physiological basis for an emotional change in pregnancy because of the increase in hormone production. The expectant woman needs help, reassurance. During labor

she has an almost childlike attitude. Her emotions are very close to the surface. She needs to know she is not alone — that she is doing a good job. She needs encouragement, friendliness, warmth. The T.L.C. we give to children is needed here as well.

Emotional care is essential for the baby. Early security and love are vital. Encouragement of family unity is important to this security and love. Father should not be forgotten either. It must be remembered he is under stress too. Especially if he is a new father he may be having difficulty adjusting to fear for the safety of his wife and baby as well as being under economic stress.

There is a problem in setting up standards of care that take into consideration emotional support. Physical care standards can use measurements of mortality and morbidity, life and death, infection or no infection, defect or no defect, amount of equipment and numbers of personnel, etc. But in setting up standards for emotional care, how do we measure well being? How do we measure satisfactions of mother, father, and baby and what these mean to health? This is a very difficult area for study because of the many variables, the nebulous aspects but perhaps we can set up criteria as we become more familiar with the needs of the families.

Nursing in this Program

What do the trends I have spoken about mean to nursing? Nursing is called upon from all sides. There is no lessening of demand. There are increased responsibilities, increased tasks.

Some of our critics say we have not accepted this philosophy of supportive care and that we are too apt to give physical care first importance. Dr. Goodrich[6] is one such critic. He says:

> The evolution from home to hospital deliveries has made nurses excellent administrators, performing duties such as the recognition of complications, progress in labor, recognition of proper timing for medications, protection of the patients from injury, but no longer skilled in true obstetrical nursing.

By "true obstetrical nursing" I believe Dr. Goodrich is referring to what I have termed nursing that gives support in all its many and varied aspects.

Dr. Grantly Dick Read[7] criticized us for what appears almost worship of our mechanical devices — our wonderful delivery tables, our efficiency. He says we appear to have forgotten the "feeling side of care."

Presuming then that we accept the principle of supportive care and that each mother, baby and father receive the physical, instructional and emotional support they need, we take on the obligation of seeing that as far as possible this comprehensive care is given.

It is interesting if we look at the definition of nursing provided by the National League for Nursing: nursing is physical and emotional care, teaching and the promotion of health. It is very similar to what I have been describing as "supportive care." I am not suggesting something new or different. It appears that good support is just good nursing.

We may need to pay greater attention to our interpersonal relationships. Our contacts with people are more important than we realize. The humane, gentle, understanding contact is just as important to the patient as the medicine we see she gets. Too long we have geared our training and service to meet the abnormal not the normal. I read recently a plea to bring "compassion" back into nursing.

Assuming we are in agreement, that reassuring the mother in pregnancy, allaying her fears and apprehensions, is part of our nursing task then how do we do this? Do we do it by simply telling the woman not to worry or do we lead parents to tell us what they know, feel and think? Do we realize that sometimes support can be just as simple a thing as holding the mother's hand as she finds herself in the frightening bustle of the delivery room as an anesthetic mask is being placed over her face.

Nurses are thinking a good deal about their responsibilities in filling the needs of parents. I would also like to refer you to the research study — "Nurse-Patient Relationships in a Maternity Hospital[8]." This is a research project of the type that has been and can be carried out by nurses. The study took place in a New York hospital and was designed to discover

what maternity patients felt was the nurses' role, to find out what nurses felt to be their role in relation to their maternity patients. In this particular situation priority was being given to the technical functions of the nurse. It is not surprising that the conclusion reached was "continuation of the present policies and practices holds little promise that the currently unmet needs of patients can be filled by nurses."

Always when we think of changes in nursing we must think of the education of the nurse, of her basic preparation for nursing. There appears to be an increased effort to give the nursing student knowledge, skills and appreciation that will assist her in her relationship with others. We have come through the phase where many of us thought all we had to do to instruct was to tell people the rules of health, to place these before them as on a platter to have them gobble them up. We learned the hard way that people do not learn in this way. That is not the way to change behavior. There are difficulties in conveying the principles of teaching, of counselling, of giving skills in communications to the young nursing student. There are many problems in producing students who are mature in judgment and able to guide people to their own solutions.

There are many advanced courses in obstetrical nursing but too many of them emphasize the surgical, physical routines, the preparation to deal with the abnormal and are lacking in a consideration of the broader aspects of which I have been speaking — the emotional and instructional support needed as well as the merely physical.

I became interested in maternal and child care when giving expectant parents classes. I wished to know more about this aspect and enrolled in the one year course given by Columbia University, New York. Midwifery training was part of the program and I honestly felt this might be a waste of time. I was not preparing for the mission field and I could see no use for midwifery skills especially since my main goal was better understanding of prenatal teaching. However, far from this experience being a waste of time I found the midwifery the most stimulating, enlightening part of the course. I was brought close to the needs of mothers, fathers and families as in no other way. We followed the normal mother through, giving support as needed prenatally, in the delivery, and with the baby.

Inservice education is also an essential for nurses on the job. Conferences, educational programs, the opportunity to talk things over are all important. The Manitoba Provincial Health Department has developed an interesting educational project in their sponsorship of an on-going program to improve prenatal teaching. A significant aspect of this program is that it is for both hospital and public health nurses. This is an example of "cooperative understanding" and is one way of "communicating, interpreting and integrating." It shows a realization that public health needs the hospital, the hospital needs public health.

Important as it is to prepare ourselves to meet the supportive care needs of parents and family we must remember to check that needs are not ones *we* have decided upon but are ones we have discovered from parents — needs that are genuine, are valid.

Nurse-Patient relationships in a Maternity Service

In this study 66 women were interviewed prenatally and postnatally in regard to what they expected from nurses in their obstetrical experience. The women appeared to expect physical support but not too generally to expect instruction or emotional support from the nurse. In many instances they seemed to see the nurse very busy with routines, getting patients in to the doctor, assisting the doctor. Rarely did they see the nurse as a person able to sit down and discuss problems. If this is the way patients consider us it seems very possible that we not only have to prepare ourselves for a changing nursing role but also to prepare our patients to accept changes in our role. We may have to guide mothers and fathers to expect and seek help from us more readily in the areas touching on their problems, their fears and worries.

Nursing Satisfaction

It has been said that many nurses do not like work in maternity services in hospitals. I wonder if nursing satisfaction in these services would increase

if we came closer to our patients and families in this program of supportive care? Recently, in a hospital obstetrical department, I found myself puzzled, frustrated, and rather unhappy with practices that I was seeing and taking part in. Many times mothers were left alone in labor and appeared distraught and tense. In the delivery room with the extensive draping and positioning the mother so often seemed forgotten except as a uterus. There was little if any effort made to allow the mother to see and hold her baby. In a home delivery service the situation is so different that it is startling. The type of woman seen in the hospital and the home services are much the same but in the home atmosphere there was a feeling of nearness, helpfulness, a close working relationship.

Segmented care or a lack of continuity of care may be a factor in nursing dissatisfaction since such care is a barrier to coordinated support for families and so can lessen nursing satisfaction. In health services we find segmented care in many areas. The nurse who deals with the family prenatally does not follow through to see the result of her teaching. In the hospital maternity services so often there is a nursery nurse and a postpartum nurse. The one who looks after the baby so often appears to forget that the baby has a mother. The other looking after the mother, appears on the other hand to forget that the mother has a baby. Such arrangements lessen nursing satisfaction.

As an example of what might be done to improve continuity of care and so to increase nursing satisfaction, consider the obstetrical services at Johns Hopkins Hospital, Baltimore. There, nurse-midwives follow through with mothers from their prenatal clinic. These nurses are on call when these mothers come into the hospital, are with them during labor and delivery and then give postpartum care in hospital and again at the clinic.

By increasing nursing satisfaction in maternal and child care we should start a chain reaction. If nurses were more satisfied in services designed to give supportive care, then the service would be improved and in turn nurses would be increasingly satisfied.

There is no question that if we are going to give supportive care time with the mothers will be needed. Proper counselling or guidance cannot be hurried or left. Time must be arranged. This means changes in routines — finding out what routines are strictly nursing, and which of the routines that keep us so busy we can give to others. It has been suggested that a technician instead of a nurse could help the doctor in his delivery room procedures. This is the type of review of routines that will be needed to decide what nurses should do. Can we relieve them from some routines in order that they may take on other tasks that bring them closer to the patient — closer to true supportive care?

If, in thinking of support for our maternity patients, we accept the idea that mothers should not be alone in labor, how do we revamp our work or train others to take over this needed care? Can the fathers be prepared and used in this situation? What is the role of the nurse? Does a nurse have to be with the mother in labor constantly in order to give support? Are there auxiliary workers who might help? Should we think of a supportive nursing care team — in the labor room, the nurse working with auxiliary help and the father in filling the needs of the mother, in the postpartum period the nurse realizing that the mother and father can be members of the team in the care of the baby?

There will have to be a revaluation of our nursing role and of what we want patient care to be. We will have to try fitting our routines to the patients not the patients to our routines. The Canadian Conference on Nursing brought up the same point when the question, "Is a nurse performing duties which should be the responsibility of others?" was asked. Many of us are reluctant to give up many routines.

We will have to study our day-to-day activities. The emotional and instructional supportive care might not take as much time as we think. In some instances it may mean only a reorganization. I am reminded of the example of the ward supervisor on a maternity floor who, when the student nurses came to her while the babies were out with their mothers asking her what they should do now, set them to cleaning bed pans. To refer again to the

suggestion that a technician might assist the doctor in the delivery, we need to look at and decide what the nurse should be doing. Is having the nurse hand sutures, forceps, swabs more important than having her relieved of this routine at the foot of the delivery table to stay at the head to give reassurance and help to the woman?

Maternal and child care is a fascinating area for study with numerous interwoven aspects that take our minds off in all directions. Most if not all of our problems, can come nearer a solution if we foster cooperation and understanding among all involved.

I would like to close on what I feel is an appropriate and optimistic note, a remark made by Dr. John Whitridge[9], associate professor of Obstetrics and Gynecology at Johns Hopkins University. He was speaking about the problem of reproductive wastage but his statement applies to the whole field under discussion.

> We have only to push open the door to cross the threshold and enter a new era that will vitally affect the lives and future well being of at least one hundred million potential new human beings each year throughout the world. This means that we probably hold the key to survival and happiness for more people in the world than any group except those who control the trigger of nuclear weapons.

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The Role of the Nurse-Midwife in Great Britain

ALICE C. MILLS

MIDWIFE ! ! ! What does that word mean to you? Does it call to mind a Sarah Gampish figure or does it make you think of a nurse who has specialized knowledge and skills in the obstetrical field? When lay people ask me what I did in England and I say I took a course in midwifery, I know they think I am a relic from the dark ages.

Midwife means "with wife." She is a woman who assists other women in childbirth; a female accoucheur or obstetrician. Midwifery is defined as the art or practice of assisting women in childbirth. Even though the *meaning* of words is most acceptable, the words in themselves are not used in Canada. Before the role of the midwife is conceded by the medical and nursing professions as well as lay people, I believe that the name must be changed. Would "obstetrical assistant" be appropriate and acceptable?

The practice of midwifery is as old as time. Originally, the midwife was any woman who assisted a mother during labor and delivery. Such women gained their knowledge from experience. For the most part they were uneducated and untrained according to

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our standards. This is not so in civilized countries today. As the practices of medicine and nursing education have advanced so has the specialized field of midwifery.

To practise midwifery in Britain one must be a State Certified Midwife which requires one year's training after obtaining nurse registration and entails two sets of examinations. The training is divided into two six-month periods. Part I is spent in a hospital and includes theory and experience in prenatal care, prenatal classes, outpatients' clinics, care of the prenatal patient requiring hospital care, postnatal and newborn care and the nursing care of the premature infant. In order to qualify for the Part I examination a nurse must have conducted at least 12 normal deliveries, having cared for these patients during their labor. During the whole period one works under the supervision of a qualified midwife. The pupil must pass Part I examinations before taking Part II. All examinations are arranged for by the Central Midwives Board. Part I examination includes a written and an oral examination. In the latter each pupil is questioned individually by a midwife and an obstetrician.

Some hospitals are just Part I schools; others are Part II schools; and some have facilities for both. Part II can be spent in domiciliary or district midwifery or three months in hospital and three months in the district, depending on the facilities and policy of the Part II school. One gains further experience in nursing care in the whole maternity field. One becomes more adept at spotting abnormalities prenatally, during parturition and postnatally. All abnormalities are immediately reported to the patient's doctor. The midwife is trained to cope with the normal, and with the abnormal only when a doctor is unavailable or until medical care is procured. In Part II the pupil midwife writes case studies on 12 of the patients she has delivered. Each case study includes the patient's obstetrical history, prenatal examinations, a detailed account of the labor and delivery, the postpartum period, including the care of the newborn, birth weight, gain, care of the cord, method of feeding and so on.

In the Part II examination the pupil is given a prenatal patient whom she has never seen before. In 10 minutes she has to find out her medical and obstetrical history, history of this pregnancy, take her blood pressure and do an abdominal examination to determine the gestation period, position of the baby, whether or not the head is engaged, etc. The midwife and obstetrician then ask questions on her findings and also about the case studies she has prepared.

Ninety-six per cent of all babies born in Great Britain are delivered by midwives either in hospital or homes. This means that ninety-six per cent of the births are normal or a midwife would not be attending them. Sixty-five per cent of all births are in hospital, the remainder at home.

There are 17,000 practising midwives in Britain; of these 7,500 are in domiciliary or district practice. Every practising midwife must have a refresher course every five years. Her practice is governed by the Rules of the Central Midwives Board.

In 1957, 264,200 births took place in homes with the lowest maternal mortality rate ever recorded — 39 per 100,000 live births. The most recent figure for Canada is 70 per 100,000 live births. Wise selection of patients who may have their babies at home is essential to good maternal care. If an emergency does arise in a home confinement, an ambulance is called to take the patient to hospital. In the event of a postpartum hemorrhage, when a patient cannot be moved, the "Flying Squad" is called. There is at least one doctor and a midwife on the Squad and they have the equipment to give emergency care and blood transfusions. In the six months I was practising midwifery I did not have occasion to call them nor did I hear of any such calls being made.

There are definite criteria for patients who shall have their babies in hospital: any patient who has had a Caesarean Section; primiparas, particularly elderly primiparas; a primipara breech; patients with poor obstetrical histories, e.g. forceps delivery, postpartum hemorrhage, toxemias, anemias (hemoglobin 65% or under). When a patient refuses to go to hospital it brings a whole gamut of problems, but the midwife is obliged to attend her.

In district midwifery the patient must book her doctor as well as the midwife who will attend her. She must be seen by her doctor at least twice during pregnancy, once quite early and again at 36 weeks. In fact, most of the patients see their doctors more frequently as well as going to the county clinic conducted by a county doctor and the county midwife. Most midwives are now county employees; there are very few in private practice; even in private practice these rules apply.

I wish to make some comments on the differences in obstetrical care in Britain and Canada from my own observations. In Britain, labor and delivery are treated as normal processes. Here it is almost a surgical procedure. A patient is scrubbed with an antiseptic solution and sterile towels and instruments are used. There, everything was clean and we did not get infections. Of course, in the home situation one seldom gets any infections, because, as we know, patients are immune to the bacteria in their own homes. Unless it is a forceps delivery with the doctor in attendance the patient is conscious and she is never, never restrained. I found that maternity patients did not need to be restrained. I have worked in several hospitals in this country and for some reason most of us feel better if the patient's hands are fastened. They can't get into trouble. If we have many mothers who require restraint, there is something amiss in their care either before or during labor. In the prenatal classes we hold in Prince Albert we try to prepare the mothers for what will happen in labor. Several of them have a real fear of having their hands tied.

In normal deliveries in Britain the patient is given either gas and air or Trilene which she administers herself. The machines are set so they cannot take enough to become completely anesthetized. In some of our hospitals the patients who have normal deliveries are unconscious when their babies are born. This is becoming less common with the use of Trilene. A mother is deprived of the meaningful experience of childbirth if she is unconscious. Normal deliveries are conducted with the mother in the left lateral or dorsal position, not in lithotomy. The patient in Britain is almost never left alone in hospital and never in the home. We know this is not the case in this country. We have the pressure of work which makes it impossible for someone to stay with the patient in labor. Primiparas in particular are afraid to be left alone and understandably so.

There, maternity patients have tub baths up until the time they are delivered. Often when a primipara was having an extended first stage of labor, we would give her an enema and warm tub to stimulate uterine contractions. Enema and a tub bath are routine for medical inductions and at the onset of labor. Patients have tub baths daily from the third day postpartum.

In Britain, a baby's head is never held back. We have all done this at one time or other during our nursing training and since because we were told to do so. I am sure that none of us felt it was right. We are all aware of the possible damage that may be done to the baby and the physical and emotional suffering of the mother.

The average stay in hospital in England is ten days. A patient delivered at home is under the supervision of the midwife for 14 days. Patients here have an average stay of about five days. Breast feeding is accepted by both mothers and midwives in Britain. The hospital stay of 10 days helps in the establishment of breast feeding. Patients, particularly primiparas, are given considerable help in feeding their babies. Five days is too short a time for a mother who is having difficulty to establish breast feeding satisfactorily. I learned a great deal about the care of breast and breast feeding.

Both the hospitals in which I worked had a modified form of rooming-in. The babies were in cots beside their mothers in the wards except during the night. Because of hospital routine they were fed at four-hourly intervals. At home they are fed on demand and few problems are encountered with engorged or infected breasts. In both hospitals on the fifth day the mother changed her baby's diapers as necessary and from the seventh day onward bathed her baby. In this way the mother knew her baby and had confidence in attending to his needs. There are very few hospitals here that carry out even a modified rooming-in plan. New

hospitals are being built and maternity wards equipped without considering the possibility of such a plan.

In the February *Nursing Outlook* there is an article "Maternity Nursing Education — Yesterday, Today and Tomorrow" by Hazel Corbin, general director of the New York Maternity Centre. She states,

> It is beginning to be understood that the quality of the childbearing experience and the satisfaction derived from it may affect the development of maternal feeling and the all important postpartal physiological and emotional interaction between mother and child.

These psychological needs have been met in Britain because of the way in which midwifery has evolved. These needs are not being met on this side of the Atlantic. Doctors are our midwives and because they are disease-oriented, obstetrical care has a pathological rather than a psychological approach. Consequently maternity nursing has the same pathological approach. Nurses are busy carrying out impersonal techniques instead of offering comfort and care to the whole woman. Interest in efficient routines overshadow concern with patient care. In 1932 the New York Maternity Centre opened as the first school for nurse-midwifery training on this continent. Since then midwife training centres have been set up at five other American centres. There have been some 500 nurse-midwife graduates. Even now there are only 40 graduates annually from these six schools, and they are quickly snatched up for underprivileged areas in the U.S. and abroad.

There is very real concern for the care of the maternity patient in the future. It is estimated that in 1970 there will be six million babies born in the United States. By all present trends in medical education there will not be enough general practitioners and obstetricians to cope even with the deliveries with the result that the deliveries will of necessity be done by nurses untrained in midwifery. Dr. John Whitbridge of Johns Hopkins University asks,

> Why is it that we find the main obstacle to nurse-midwifery coming from the very people who should be in the best possible position to evaluate the situation? There are, of course, many probable reasons, but the most significant ones are as follows: The average physician, be he general practitioner or obstetrician, knows very little, if anything, about nurse-midwifery or how a nurse-midwife might function in our present system of medical care. He is inclined to think in terms of the non-professional untrained midwife and concludes that any system recognizing an individual called midwife is automatically turning back the clock to an era from which we have largely emerged. In other words, the vast difference between midwife and nurse-midwife is greater than that between a first year medical student and a board certified specialist. This difference is not recognized. A second basic misunderstanding relates to the way in which nurse-midwives would function. There is the apparently widely held view that they would be private practitioners and thereby in direct competition with physicians. Nothing could be farther from the truth, since all of us who are interested in furthering the development of nurse-midwifery in this country emphasize the fact the nurse-midwife would at all times be working under the close supervision of a physician, as a member of the obstetric team. The nurse-midwife furnishing direct service to patients would be a salaried employee of either a practicing physician, a hospital or other agency furnishing direct care to patients.

Dr. Whitbridge thinks that until the nursing profession decides on educational qualification of nurse-midwife students we will not be in a position to undertake their training on the scale that is necessary.

You may say, "These problems do not apply to us in Canada." Actually, we face the same problems in obstetrical care. Until the role of the nurse-midwife is accepted the approach to maternity care will continue to be geared to the abnormal rather than the normal.

We cannot expect radical changes in the practice of obstetrics in a short period of time. Is it possible to make gradual changes? Instead of sending nurses to take postgraduate courses in obstetrical nursing would it be of more value to have them take nurse-midwifery courses? Nurse-midwifery train-

ing is a humane, psychological approach to the normal woman to meet normal needs. With the facilities we now have available, is it feasible that a woman in labor never be left alone? If we do not have the staff, can we consider allowing husbands to stay with their wives? Can we dispense with restraining patients in the second and third stages of labor? Are our reasons for doing this really valid if we think consideration of the mother's comfort and feelings important? What can be done to help a mother know her baby and how to handle him before being thrown on her own resources at home? What can be done about holding back a baby's head or anesthetizing a patient until the doctor arrives? There are many problems and situations to be solved before mothers can receive the kind of care they have the right to expect. To quote Dr. Whitbridge again:

> There can be no denying that childbearing has become unbelievably safe, but it would scarcely be considered adequate in our modern society. The satisfaction realized by mothers through the birth process, the happiness of parents and children, the presence or absence of chronic disability — both physical and emotional — the quality of the offspring, and many other factors must be considered when assessing the end results of obstetrical care.

Why Judge Them?

SISTER STE. MECHTILDE, S.M., M.A.

The Problem

WHEN an unmarried young woman becomes pregnant there are usually several factors that are suggested as possible explanations: her youth, her loneliness, her inexperience, or her irresponsibility. Where does the blame lie?

In order to understand and help these unhappy young women who have been carried away by a too-yielding disposition they should not be judged by their outward appearance nor blamed for the company they keep, the use they choose to make of their leisure, the magazines and novels they read, the movies they see, the music they listen to or the dances they prefer. What we should seek to understand is *how* and *why* they have become what they are: day by day becoming more egotistical and less truly feminine. We will learn that these young women have not struggled very hard against the environment in which they live. Their home surroundings perhaps, or the social life they follow may have warped their outlook. Their goal in life is bounded by their desire for adventure. They long to love and to be loved but they have not succeeded in finding the person who will point the road to true love.

That is roughly a picture of the unmarried mother who turns to us for help. We must look upon her with kindly eyes, and an open mind. This picture makes us aware especially of the importance of parent-child relationships. Before any educational program

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is started the father and mother should "tame" their child as St. Exupery notes in "The Little Prince":

> What does it mean to tame?
>
> "It is one thing that is often forgotten," said the fox, "It means to build up some ties. If *you* tame me, my life would be bathed in sunshine."

Child training is a difficult matter that is based on love. One of the immediate forms this love will take is *confidence*. We can predict if a child is going to become a happy or an unhappy adult when we learn if the early years have or have not been dominated by this feeling of confidence.

The Causes

Over and over again, stories are told us by the young women that show the relationship between a happy life and the influence of parents on their children. These girls would not know much contentment with a cold mother or an inaccessible father. We know that at the bottom of their hearts most parents love their children but they show their love in a fashion that is not always what the child needs. For example, the rich father who sends presents to his son from far and wide every time he goes away, finds he avoids embarrassing contacts so long as he is away. He avoids the questions he finds it too difficult to answer. This father should take care lest he some day wakens to the realization that this behavior may have cost him dearly -- not just in money but even more in uneasy anxiety. He will know then the gap in understanding that exists between his son and himself.

There are many other barriers that can be raised between a father and his daughter, the daughter and her mother if they do not weigh their responsibilities carefully. Perhaps mother is more concerned about her fur coat, a fishing party means more to father, or entertaining their friends. The children who have to suffer from this lukewarm attention will spend the rest of their lives in a vain but obstinate search for the love that should completely fill their lives.

It would be easy to cite hundreds of examples of unmarried mothers who nearly always are seeking for the kind of love that they believe will last. Why does this driving urge exist? Because their parents are not *there* in the full sense of the word. True, they may be present in the flesh but if we consider the number of broken homes, it is not difficult to understand why they fail to develop a sympathetic understanding with their children, why they fail to listen to the hopes for the future the young people have.

The absence of the father constitutes a state that might truly be termed "family insolvency." Not the least of the ways in which this is evident is in the education of his daughter. I do not know if you have read the novel "Misery without a Name" where is written:

> The young girl who has never really known her father regards all men with an indescribable mixture of curiosity and anguish. When she gives her love, she is slowly conscious of a feeling that is genuinely filial which raises her up then dashes her down, full of misunderstanding for every other person she meets.

Family insolvency . . . what dramas are wrapped up in those words! How can those who have been brought up in a normal, united, happy family imagine the suffering of one who has grown to maturity in a loveless home? It is necessary to be close to this misery for a long time, daily and near at hand, in order to appreciate the incomparable gift that is taken for granted by those born to a home where love abounds.

Without parents, the young of animals can survive for only a short time in conditions unfavorable to their species. Young humans, on the other hand, may grow to adulthood under adverse conditions, but at what a price! How can they hope to meet well balanced, happy people under such circumstances? As for the unmarried mother, she knows little happiness before or after the birth. Human psychology does not dispute the fact that the intensity and quality of the love of parents is closely associated with their love for each other as husband and wife.

What can be done?

It is the harmony and stability of a married couple that ultimately determines the success of the teaching they give as their child is developing toward maturity. This shows again how definitely the parent-child relationship is of fundamental importance.

The parents ought to be told. They ought to be aware that they have the magnificent but formidable privilege of helping their children grow up in every sense.

During the early years, the mother is the one to whom the child turns for tenderness, for comfort when there are difficulties and particularly for understanding when mistakes are made. She remains the model, the confidante who is usually more accessible than the father, the counsellor of whom any kind of question can be asked and who always has a simple, truthful answer. To measure up to all of these responsibilities, it is important that the mother should be available when the child needs her and also that she should take the time to give the comfort that is sought or to answer the questions that are being asked. The mother should not allow pressure of work or chores, in the home or away from it, to disturb her calm approach to the child's needs.

On the other hand, an excess in the quality and quantity of parental love is almost as harmful to the child as too little tenderness and security. Parents who overwhelm their children with love, who are too anxious for their well-being, too possessive, too dominating are doing untold harm. If only parents could *accept* their children as they are, without restrictions and without expecting them to compensate for their personal weaknesses, without trying to make them into the fulfillment of their ideal. Rather, parents should respect each of their children for him or herself; no child learns the meaning of true love when she has not learned self-respect.

Children have a great need for truth. When they stumble in their behavior why say to them: "Do you think I did not have difficulties to face when I was your age?" Why recall the past? Is there so much to praise in our own conduct that we are always above reproach? Have we no temptations to cope with now we are adults? It is often said of the adolescent "Oh, she is at the age of crises!" Be realistic. People of 50 are just as likely to be confronted by crises.

Why does this barrier between our lives, our world and that of our children exist? There is a grave risk that they will develop an unrealistic attitude toward life if, unintentionally, they are offered easy solutions to every problem. They should be taught that life is a struggle. They should learn to see their parents as they really are: human beings living close to each other, who rejoice and love, who struggle, fail and begin again, without making a mystery of the whole business. Children should realize that parents try to shield them from cares that would weigh too heavily on their young shoulders.

Rehabilitation

Because the threads of family life are sometimes so tightly tangled, when a serious problem, such as the one that we have been discussing, comes to us careful thought must be given to plans for rehabilitation.

A young woman in need of help comes to us. Usually she is in a panic, not knowing what is going to happen to her, knowing only that she is in trouble. She is dreadfully afraid that she will be rejected. First we must give her a place of refuge that not only shelters her and provides her with necessary care but also that gives her the emotional security of being surrounded by people who understand her problems.

In a few localities, there are special homes for the adolescent unmarried mothers. The aim of these homes is to help the young woman to establish satisfactory relationships with a restricted group so that she may develop a point of view that will eventually make her a useful citizen. The girls begin to realize that someone cares, that they are not alone. In this home away from home the physical, economic, educational, recreational and spiritual needs are met. There, surrounded by healthy positive relationships, with a staff that is truly interested in their welfare, the girls develop new sets of values.

The staff in the home includes specialists such as the teachers of cookery, sewing, ceramics, hair-dressing, physical education as well as the obstetrical team of doctors, nurses, social workers and psychiatrists. The girls go about their work individually or collectively absorbing something of the spirit that leads to the discovery, development and

blossoming of their personalities. While creating a homelike atmosphere as far as possible, we try to revitalize parent-child relationships by encouraging the parents to visit their daughters, the daughters their parents. Perhaps it will be dinner downtown together or a weekend spent with the family.

Through our public relations program we have developed an interest in our home among some of the service clubs. This gives us an opportunity to present a true interpretation of the problems to a good part of the community. We try to arouse their collective consciences to an appreciation of the gravity of the situation. Though these clubs have helped us financially we try to make the members realize that their responsibility does not end there.

To meet the needs of young women from families with comfortable means, we have acquired a manor, of Norman style, magnificently situated in a secluded area. With accommodation for ten "paying guests," the primary purpose of the new residence is to provide a place near at hand rather than have these girls disappear to an alien area. Having plenty of money does not exempt these unfortunate young women from the sufferings of moral anguish. We interpret our role in these cases as ameliorating as far as we can their wretched unhappiness.

Another project we are developing is to provide lodgings for seven or eight girls who are continuing to work but lack a suitable place to live. Run by a married couple, this boarding house will show the hapless young women what normal family life should be like.

The Results

Do all these organized efforts really accomplish anything? Are the girls themselves helped? We have few illusions! Human nature and society being what they are, the problems will continue to exist. We must hope for the successful rehabilitation of these young women. Only by exercising patience, devotion, perserverance and generosity will a transformation follow. Many of the young women come back to see us and the very fact that they do come holds hope for the future. Some of them say:

> It is difficult at times. Sometimes we are very envious of others but the help and encouragement you have given and are still giving us supports our vow to be real women.

Some of them marry men who continue the development we have started. In their own homes they get a new appreciation of human values and the mystery of true love. There are others who write or telephone us, saying: "I have grown up. I am not like I was. Life seems different. I've thought about this a lot." Or, "I want to be someone. I've begun my studies again and I'm doing something with my life."

We must remember that the problems that human beings have to meet are universal. Those facing the unmarried mother are not unique excepting that her problems must be solved in such a way as to restore her confidence in life and in people.

Finally a word to parents who have or will have teen-agers in the home. Speak to them often about life. Show them that you understand their development and their problems. Praise their capabilities. Show them their own resources. Don't let them read indiscriminately. Don't let them have their own way in everything but try to give them a taste for sensible and good things. Let them become progressively more independent of you so as to strengthen their own personalities. Do not be afraid, when it is necessary, to say "no." Adolescents need security of parental control. Ho, they won't want to admit all this but they will be grateful, knowing that they may lean on someone who is stronger than they. Parents who take a definite stand on moral issues — what is bad and what is good — give their children courage for a crisis.

The whole art of teaching is only the art of awakening the natural curiosity of young minds for the purpose of satisfying it afterwards. —Anatole France

Old age, especially an honored old age, has so great authority that this is of more value than all the pleasures of youth.
— Marcus Tullius Cicero

Planning Senior Experience in Obstetrics

HELENA C. E. MANN

IN RECENT months I have had people ask, "What do you do with your students who return to you during senior experience? What do you give them?

This idea of students returning in various specialities for additional experience in their senior year is not a new one. It was initiated in this school because it was felt that the students were not prepared to function as graduates, according to our modern expectations, without additional experience and preparation. So this needed experience in different areas was planned for each diploma student in this school, and provided for in her overall rotation.

As in all new programs, we become very involved in developing a satisfactory teaching pattern. Since, for the first year, all we had in each area were students assigned for junior experience, we devoted all our energy to planning a good basic course for them. When we suddenly realized that we had three senior students arriving every four weeks for added experience on obstetrics, we were a bit dismayed. What were we going to do with them? We certainly didn't feel that they could continue on the level they had left as juniors but what else was there? How could we plan a meaningful four weeks for those students?

First, we tried to decide what we wanted to accomplish in those four weeks. The students had already had their complete theoretical background in the 12-week junior period. They had also had planned experience in the three obstetrical areas — delivery rooms, lying-in ward, and newborn nursery. The only area in which they had not had experience was the premature nursery. After some consideration we set up the objective for the senior term:

> To give the student more advanced experience and responsibility in obstetrical nursing to enable her to become a more proficient and confident nurse in the area.

With this objective in view, we planned fresh experiences in each of the obstetrical areas.

In the case room the students spend a four-day period "on call," that is, they are called for a specific patient, and have the responsibility for caring for one patient in labor through delivery. This practice is patterned somewhat after the midwives' training. It is hoped that this system will give the student a more integrated picture of the progress of labor, and the emotional support and physical care she is responsible for during that time. In conjunction with the patient assignment, she is given a written assignment to help her organize and clarify her observations and care.

Her experience on the ward is directed also toward helping her gain a more comprehensive, over-all view of the care of the patient, this time postpartally. In this hospital the team system of nursing is in effect. The senior student is now team leader on days and on evenings relieving the graduate in charge of that shift. Recently we have had the senior student give weekly organized classes to the nursing mothers on caring for themselves when they go home.

The period in the nursery is devoted to the care of premature infants. She is responsible for the nursing care of the babies, under the supervision of the head nurse in the nursery.

It was found that a brief orientation period was necessary for these students as, for most of them, a year had passed since their previous experience. This orientation includes such things as: what is expected of them in their student experience, explanation of assignments, review of changes in equipment, procedures and policies since their junior term.

Supervision during the senior term is provided almost entirely by nursing service personnel after initial instruction and supervision in the new ex-

Miss Mann is clinical instructor in the Department of Obstetrics, University Hospital, Saskatchewan, Sask.

perience by the instructor. Evaluation of the students is shared by the nursing service personnel, the instructor and the students themselves. Academically they are evaluated on the basis of a 20-minute oral examination conducted by the supervisor and the instructor.

Personally the students evaluate themselves in the conference with the instructor, who has had informal conferences with head nurses and team leaders regarding the student's performance and progress.

This system of senior experience was not all a bed of roses! Of course it had accompanying problems. The case room portion seemed to have most since it was a new and unfamiliar pattern. However, now that our students and graduates have become accustomed to the system and understand what it tries to accomplish our problems have practically disappeared.

This program is shared by all diploma course students in the school. In addition there are some students who may choose, if they have some spare time in their training, to return to obstetrics for further experience. These students participate in the planning of their own programs which are geared more to the administrative level. They invariably ask for a period of nights on the lying-in ward. This is usually possible. They attend prenatal classes given by the supervisor and give a series of prenatal relaxation classes under her supervision. These students spend one afternoon with a local doctor who very cooperatively arranged to see only pre- and postnatal patients on that day. An important part of this experience is a period in the delivery suite working as junior graduate and team leader with the senior graduate in that area.

As far as assignments are concerned for this special experience, there are none. The students are given an outline for evaluating prenatal classes, noting such things as approach of the teacher, type of material taught, patient's reaction, and so on. In the case room they are asked to note points in relation to administration, such as how the area is organized to meet various obstetrical emergencies, what system of assignment is used, how supplies are ordered, etc.

The optional seniors, as we called them, participated in the planning of their program, then evaluated their experiences with us at the end of it. The general reaction was that they had gained from the experience and had enjoyed it. This period varied in length from two to four weeks. In a longer period these students could likely be given more opportunity to teach junior students.

The students in general like a senior term in these different areas because they feel that it serves to give them a much wider perspective, and a general consolidation of all the impressions and experiences obtained in their junior term. Planned with this end in view, the program seems to have accomplished its purpose fairly well. We plan to continue it — constantly assessing and revising it, to keep it meaningful in terms of opportunities and responsibilities our students encounter as they leave the school.

Robert B. Lloyd, administrator of St. David's Community Hospital, Austin, Texas, reports that patient polls, by the written questionnaire method, often show that a change of policy or practice is necessary, repairs to equipment are needed or that certain personnel changes are advisable.

The following guide rules are suggested:

1. Questions should cover as many of the personnel and departments as possible.
2. Put yourself in the position of the patient; phrase questions directly — include only those that may be given quick replies.
3. Do not identify any patient by name or room and provide space for comments.
4. Distribute questionnaires at discharge with the request to return by mail.

The administration has learned much about patient's reactions and often becomes aware of a problem before it becomes serious.

— *Hospitals*, July 16, 1959.

Pre-eclamptic Toxemia

KATHERINE GOOS, MARIAN SELLERS *and* KATHERINE ANTONIADES

PRE-ECLAMPSIA, a toxemia of pregnancy, is one of the most common, serious constitutional reactions of a woman to pregnancy. It is a condition peculiar to pregnancy and the symptoms subside with the termination of the pregnancy. The incidence varies a great deal from country to country, and no one seems to know why there is this variation. For instance, in Thailand it is almost unheard of, yet in India the incidence is relatively high. In Great Britain 8 per cent of pregnant women may develop pre-eclampsia and in Canada 5 per cent. In Saskatchewan the incidence is ½ to 1 per cent.

Mrs. Moore was admitted to the University Hospital with the diagnosis of pre-eclamptic toxemia. She was 36 years of age and had been married for ten years. In this interval she had been pregnant four times. In 1949 her first baby was born prematurely at 35 weeks weighing four pounds. At the present time this child is alive and well. In 1950, her second pregnancy terminated at 34 weeks, in 1952 her third pregnancy at 28 weeks. Both of these were stillbirths. Mrs. Moore had marked edema with her first pregnancy and pyelitis with her second and third.

Her menstrual history appears normal. The date of her last normal menstrual period was February 1. Therefore her expected date of confinement should have been approximately November 8. This pregnancy was planned. Quickening occurred at five months. Mrs. Moore had some vomiting starting at the fifth month and lasting for about a month. Physical examination showed her height to be five feet four inches, weight 200 pounds. Her usual weight was 170 pounds. Thus, she had gained 30 pounds during the first 36 weeks of this pregnancy. Her general nutritional status was good. Blood group was B, Rh positive. The fetal heart tones which could be heard in the right lower quadrant, were 140 beats per minute and regular. The fetal weight was estimated at five pounds. The vertex was presenting. On admission, Mrs. Moore's blood pressure was 170/106. Her urine was four plus for protein. She had marked edema of the face and hands as well as of the ankles and feet. She complained of feeling drowsy, nervous, with some headache.

The authors presented this material as a seminar during their senior year at University Hospital, Saskatoon.

Signs and Symptoms

The textbook clinical signs and symptoms of pre-eclamptic toxemia include:

The average time of onset is the 30th week or later. The earliest sign, in 75 per cent of cases, is a rise in the blood pressure. A rise to 140/90 or above in the average patient is considered to be due to toxemia.

Edema usually occurs first in the ankles and lower legs. As the face and hands become involved, the patient often complains of puffiness of the face and eyelids which persists overnight, and of a tightening of her wedding ring.

Albuminuria usually develops concurrently with or after the blood pressure rise. The more severe the toxemia the larger the percentage of albumin secreted in the urine. Decrease in urinary output occurs as water is retained in the body tissues as edema. This edema is associated with excessive weight gain and it must be remembered that the edema can be occult or visible.

As the toxemia progresses the patient realizes that something is wrong. She may experience lassitude, loss of sense of well-being, headache, dizziness, impaired vision — this can be double vision, spots before the eyes, or rainbow colored rings around the lights. Severe headache, vomiting and epigastric pain are indicative of impending convulsions or eclampsia.

Our patient exhibited all the above signs and symptoms at one time or another.

Why does this condition occur? There are almost as many theories regarding its etiology as there are people looking for a cause. Predisposing factors to pre-eclampsia include:

1. Very young or very old primiparas, as presumably the organs of such women are less able than in subsequent pregnancies to adapt to altered or increased demands.

2. Increased intra-abdominal pressure as with primiparous, hydramnios and multiple pregnancies, or over-distended uterus. Perhaps with twins the increased metabolism plays a part.

3. Abnormal activity of endocrines.

4. More common in stout, short-necked, "sthenic" women than in the asthenic type.

Because the termination of the pregnancy results in the removal of all signs and symptoms, the products of conception may be the cause of pre-eclampsia. A fetal origin is not likely as the condition may be present with an hydatidiform mole. It has also been suggested that placental infarcts liberate toxic substances but this has not been substantiated. The maternal physiological changes are very complex and not fully understood. A fuller understanding of maternal metabolism is necessary before ruling this out as a factor in the cause of toxemia. A current view is that pressor subtances appear in the blood of susceptible patients in the latter weeks of pregnancy.

What happens in the body as a whole? There seems to be generalized arteriole spasm and the symptoms of increased blood pressure, edema, etc., result from this. The pathological changes first affect the liver. Ecchymoses or bruising is seen on the surface. In the more severe cases there may be massive hemorrhage. The areas of degeneration are also associated with capillary thrombosis. The changes found are most marked in that part of the lobules supplied by the portal vein. There is a connection between the uterus and portal system through the inosculation of the internal iliac veins with the inferior mesenteric. The kidneys also undergo degenerative changes. Here the epithelium of the convoluted tubules is most markedly affected. There is cloudy swelling and fatty degeneration and in more severe cases there may be coagulation necrosis. There is also capillary thrombosis and hemorrhage, and thickening of the basement membrane of the glomerular capillaries with narrowing of the lumen of the vessels. There may be capillary thrombosis, hemorrhage and edema affecting the brain as well as edema of the lungs. Degeneration of the myocardium may occur and the spleen, pancreas, intestines and suprarenal capsules may show similar changes.

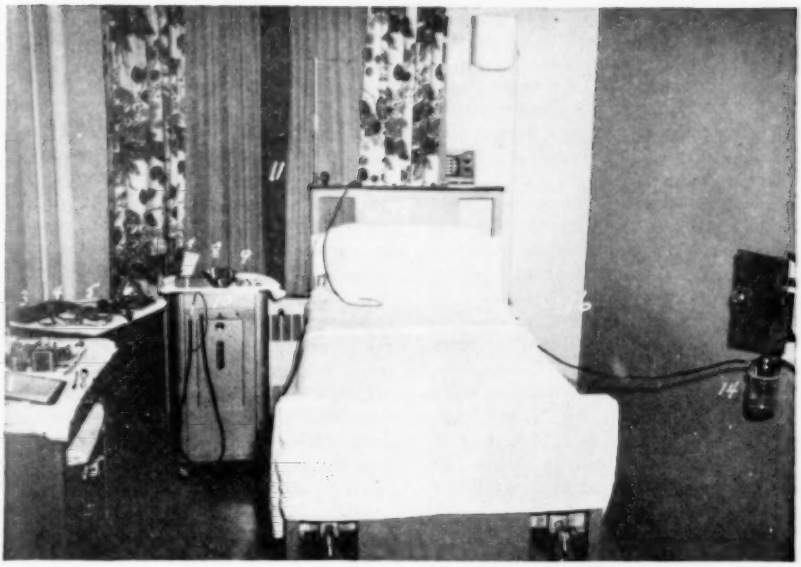
Nursing Care

Although the etiology of pre-eclampsia is obscure, much is known about the nursing care and treatment. Intelligent, conscientious nursing care is of prime importance in the treatment of toxemia. A clear understanding of the nature of the complications, early recognition of danger signs, and prompt intensification of treatment often are lifesaving. The nurse must remain in constant attendance with the patient. She must carry out the doctors' orders to the minutest detail, she must work quietly and speak in low tones while in the patient's presence. Mental as well as physical rest is imperative for successful treatment. This includes bed rest, sedation, and the reduction of extraneous stimuli to a minimum. Thus, it is the responsibility of the nurse to have the room set up with all the equipment necessary in the care of a pre-eclamptic before the arrival of the patient. This should include a blood pressure cuff, stethoscope, ophthalmoscope, fetalscope, mouth gag, facilities for giving intravenous glucose and sedation, oxygen, suction, and a retention catheterization tray.

The care Mrs. Moore received on the ward, the treatments and medications will illustrate the usual pattern:

On admission, a voided urine specimen was obtained and sent to the laboratory for protein estimation. The patient was put to bed immediately in a darkened room that had been prepared previously with all the necessary equipment. The bed had been moved away from the wall to prevent unavoidable jerking when it was necessary to work on both sides of it. The overbed table and bedside locker had been padded to offset possible noise. A blood pressure cuff was placed on the patient's arm. This was left in position in order to avoid the increased stimulation that would have resulted from putting it on and taking it off with each blood pressure estimation.

Because the patient was nervous, jittery, dizzy, had some headache, plus the



Room Prepared for a Severe Pre-eclamptic Toxemia

1. Special charts for recording vital signs, fetal heart tones, and intake and output.
2. Eclamptic tray, containing drugs for controlling seizures, and means of administering them.
3. Ophthalmoscope.
4. Fetalscope.
5. Stethoscope.
6. Sphygmomanometer.
7. Tissue wipes, curved basin, airways.
8. & 9. Tongue forceps, mouth gag.
10. Suction.
11. Dark drapes.
12. Padded bed head.
13. Indirect lighting.
14. Oxygen.
15. Retention catheterization tray.
16. Working space behind bed.
17. Signal cord.
18. Padded furniture and trays.

blood pressure elevation, she was immediately given Avertin 6 cc. in 240 cc. of water by continuous slow rectal drip — administered over a three-hour period. Mrs. Moore settled down following this.

Vital signs were taken every hour. In the blood pressure reading the diastolic pressure is more important than the systolic in evaluating the patient's condition as a rise in diastolic pressure indicates spasm of the arterioles with the result that the blood flow through the placental site and the vital centres of the mother's body is interfered with.

A retention catheter was inserted and drained every four hours. A catheter specimen of urine that was sent to the laboratory indicated 360 mgm. % of albumin. Twenty-four hour urine specimens are kept on these patients to determine the amount of albumin excreted per day. A careful record of intake and output is also kept to determine any increase or decrease in the storage of fluids in the tissues. Decrease in urine output should be noted and reported at once.

Nursing procedures should be carried out all at one time, preferably immediately after the administration of sedation in order to disturb the patient as little as possible. When any treatments are being given is a good time to change the patient's position with a minimum of excitation.

Mrs. Moore received 1000 cc. of 20% dextrose in water in the late afternoon. These hypertonic solutions are given to stimulate kidney activity and draw some of the excess fluid from the tissues. Infusions given to these patients should, of course, never contain saline.

Fetal heart tones were noted every four hours. When the fetal heart tones were being taken it was noted that the fetalscope left an indented ring on the patient's abdomen showing that there was also some edema present in this area.

Avertin was repeated in the early

evening, and amytal gr. 3 was given during the night to keep the patient sedated. In the morning Mrs. Moore was awake and talking with the nurse. Some oral fluids were taken. Routine morning care is not given to such severe pre-eclamptic patients because of the stimulation it produces.

At 9:00 A.M. Mrs. Moore was nauseated and had some emesis. She was again complaining of feeling nervous and jittery, had a headache and stated she was seeing spots before her eyes. She had no epigastric pain. It is important to ask about this, as it usually precedes the onset of a convulsion. Avertin 5 cc. in 200 cc. water by rectal drip was given as well as morphine gr. ¼ per hypo. Another intravenous of 5% dextrose in water was started with the addition of 500 mgm. of Diamox as the patient's urine output was concentrated and diminished in amout.

As will be apparent from the foregoing, the treatment of pre-eclampsia is purely symptomatic. There is arteriolar spasm resulting in high blood pressure. There is retention of sodium leading to retention of fluid and resulting in edema. There is impaired kidney function and albuminuria. The remaining symptoms can be traced back to these three factors.

Sedation is necessary to prevent convulsions. Avertin was the main sedation used with Mrs. Moore. This is administered rectally in warm distilled water at a temperature of between 90° and 104° F. If the temperature goes above this there is irritation to the rectal mucosa. The total amount administered should not exceed 6-8 cc. of Avertin for women. Before administering, it should be tested with Congo Red solution. The color of the solution should match that of an equal amount of distilled water containing an equal quantity of the indicator. If the colors do not match, the presence of irritant decomposition products is indicated and the solution should be discarded. Toxic effects include cardiac and respiratory depression. The patient should be watched carefully for any signs of this. Following administration of Avertin there may be a marked drop in blood pressure.

Morphine was also used for its sedative effect. If delivery of the baby is imminent it should be avoided as it tends to cause respiratory depression of the baby who would be very sleepy and slow to breathe on delivery. If given in too large doses or too frequently morphine may cause decreased urinary output, increased intracranial pressure, and acidosis due to decreased elimination of carbon dioxide from the lungs as respirations are depressed.

Hypertonic glucose solutions as well as promoting diuresis and reducing edema are of value in replenishing liver glycogen stores. Mrs. Moore also received Diamox. This inhibits carbonic anhydrase in the renal tubules resulting in depression of tubular reabsorption of bicarbonate. The promotion of the excretion of the bicarbonate ion results in loss from the extracellular fluid, by way of the kidney, of sodium bicarbonate, potassium bicarbonate and an iso-osmotic equivalent of water. The urine excreted is alkaline and a mild degree of metabolic acidosis may occur. The dose is 0.25 mgm. per day. Side effects include drowsiness and paresthesia.

The main points for the nurse to remember in connection with the medical treatment are:

1. Careful observation of the blood pressure. It should be taken before and after the administration of any of the sedative or hypotensive drugs.
2. Careful observation of the respiratory rate of the patient. Any changes should be noted.
3. Careful recording of the urinary output.
4. Detection of early signs of an impending convulsion — restlessness, jittery feeling, twitching of muscles, so that sedation might be given promptly.

Because of the retention of sodium in the body the patient was placed on a low sodium diet. The diet is usually a light one and may even be restricted to fluids depending on the activity of the patient's gastrointestinal tract. If fluids are ordered they will be the nurse's responsibility and she must take care to see that they are low sodium fluids.

Delivery

A patient should not be left in a severe state of pre-eclamptic toxemia for more than 48 hours if there is no improvement in the symptoms with the treatment given. Because Mrs. Moore

was 36 years of age, had had two previous stillbirths, and because her condition did not improve with the treatment given it was decided that a Caesarean section should be performed to try and ensure a live baby. Baby Ellen was delivered by a low segment Caesarean section.

The Caesarean was done before full term because it was feared that if the mother did go into convulsions the baby might die *in utero* due to a cutting off of the maternal blood supply. A convulsion might also have caused *abruptio placenta* where the placenta would have separated from the uterus completely thus cutting off the baby's supply of oxygen and food.

As a cause of fetal death toxemias are very important. In a study made in the United States it was conservatively estimated that at least 30,000 stillbirths and neo-natal deaths each year were the result of toxemia of pregnancy. This huge toll of fetal lives is in large measure preventable. Proper prenatal supervision, particularly noting the signs and symptoms of oncoming toxemia, and appropriate treatment will prevent many cases and alleviate others. The nurse is often the first to encounter these signs and symptoms, not only in the clinic but also on home visits. It is urgently necessary that she be constantly on the lookout for them so early treatment may be instituted.

Typically all the signs and symptoms of toxemia disappear after delivery, and complete recovery may occur after a week or two. Sometimes it is months before the blood pressure returns to normal. Not infrequently, however, convulsions can occur within the first 24 hours postpartum. Therefore, constant observation and adequate sedation of the patient are just as important in this period as they are antepartum.

Mrs. Moore had a fairly uneventful recovery and was discharged with the baby — a very happy mother.

In Memoriam

Harriet Ann Ash, a graduate of King's County Hospital, New York City, died recently at the Brantford General Hospital, Brantford, Ontario. She was one of the pioneers of the Victorian Order of Nurses in Western Canada having served as supervisor of the VON in Calgary for 25 years. Although she retired in the early thirties, she helped the VON in Brantford and cared for relatives and friends when she was 80 years of age.

* * *

Ruth L. D. Buckley was accidently killed in September at the Westminster Hospital, London, Ontario. A graduate, in 1955, of the McKellar General Hospital, Fort William, Ontario, she had engaged in institutional nursing.

* * *

Barbara (Fraser) Carder, the first woman to become a member of the Board of Directors of the Vancouver General Hospital and a life governor, died recently in White Rock, British Columbia. Mrs. Carder was born in Prince Edward Island, and graduated from V.G.H. in 1908.

* * *

Margaret Ann (Murray) Dennis, a graduate of the Royal Victoria Hospital in 1954, died in Halifax on August 26, 1959, after a long illness. A native of Toronto, Mrs. Dennis was on the staff of the Victoria General Hospital, Halifax, prior to her marriage.

* * *

Agnes Jamieson, who graduated from the Montreal General Hospital in 1911, died in June at her home in Winchester, Ontario. She devoted her life to private nursing and the interests of this group in Montreal. She had been president of the Montreal Graduate Nurses' Association several times.

* * *

Dorothy Kellett, one of the first graduates of St. Paul's Hospital, Vancouver, died recently in that city. She came to Vancouver in 1888, and was 96 years of age at the time of her death.

* * *

Alice Josephine (Rice) Radford a graduate of Halifax Infirmary in 1955 died recently in Kingsport, Nova Scotia.

* * *

Robert K. Troop who was employed at the Westminster Hospital, London, Ontario died recently.

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

THIS column, *Nursing Across the Nation*, is one of the many responsibilities of the National Office representative to the Committee on Public Relations. This office has been carried by the Assistant General Secretary, Miss RITA MACISAAC during the past five years.

But now, matrimony is claiming Miss MacIsaac and she is leaving the CNA staff to be married. Although nurses in Canada and especially we who have been closely associated with her work and in biennial and committee meetings regret this loss to CNA, we congratulate and thank Miss MacIsaac for the contribution which she has made to Canadian nursing and to the CNA program in particular. Now, in her last edition of Nursing Across the Nation, Miss MacIsaac looks back over the years in which she has served the CNA and highlights some of the developments that have taken place during this time.

PEARL STIVER,
General Secretary.

Canadian Nurses' Association 1954-59

Looking back over the pages of this column, as far back as 1954, we see recorded many of the accomplishments of a rapidly expanding association.

It was in December 1954 that CNA National Office moved to the capital city; it will be in December 1959 that our headquarters office will move within this city to share offices with The Royal College of Physicians' and Surgeons, gracious and efficient offices worthy of your national organization. We will risk a prediction that by 1964, the move will be to the CNA's own home, a national headquarters designed to facilitate the work of an ever-expanding program carried on in the interests of Canadian nursing.

From a professional staff of three in 1954 to one of six in 1959; from the early operation under the new CNA structure to actively functioning nationally-represented committees and to special committees undertaking activities such as the Pilot Project and the study of research needs — these are pictures of growth.

Close liaison with other national groups and with our Federal Government departments has provided opportunities for interpreting the needs of nursing and for cooperation in all matters of health. Canadian nursing has benefited from these contacts.

Two biennial meetings have come and gone — one in Winnipeg and one in Ottawa. The latter, the 50th Anniversary of CNA achieved many firsts:

Our membership exceeded the 50,000 mark.

Approval was given for a new CNA crest.

The CNA Retirement Plan was approved.

A pageant on nursing reviewing CNA and Canadian nursing history was professionally produced and widely acclaimed.

Plans for the Research Committee were laid.

The Winnipeg convention marked the launching of the Pilot Project for Evaluation of Schools of Nursing. The surveys of 25 selected schools of nursing, participating in this Pilot Project, are now completed. The Director is engaged in the preparation of the report. The general membership will vote on the recommendations contained in the report in Halifax in June 1960.

Nursing has been recognized nationally through the issuance of a stamp

APPLICATION
CANADIAN NURSES' ASSOCIATION
30th Biennial Meeting

30th BIENNIAL MEETING
NOVA SCOTIAN HOTEL,
HALIFAX, NOVA SCOTIA
JUNE 19th-24th, 1960

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NO REFUNDS AFTER JUNE 17th, 1960.

The Housing Committee under the chairmanship of Mrs. Dorothy McKeown of Halifax is working closely with National Office to insure adequate accommodation for our nurses attending the 30th Biennial Meeting in Halifax, June 19 - 24, 1960.

Already blocks of rooms have been reserved in the Nova Scotian and Lord Nelson Hotels. In addition, arrangements have been made for Sisters to be accommodated in Mount St. Vincent College and student nurses at St. Mary's University.

Other hotels, motels and tourist houses are presently being surveyed and details regarding the accommodation in these will be available from National Office.

Naturally, at a large convention single rooms are at a premium. A certain number of these must be held for our guest speakers.

It is helpful if two nurses will arrange to room together and indicate this on the registration card overleaf.

CONVENTION ACCOMMODATION, 1960

NOVA SCOTIAN HOTEL,
HALIFAX, NOVA SCOTIA
JUNE 19th-24th, 1960

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So pure and fresh in sparkling glass, Swift's new Meat Dinners for Babies are a carefully balanced combination of Swift's lean, 100% meat, vegetables and a little cereal. Like Swift's well-known 100% Meats for Babies, they're prepared from only the very finest ingredients. The leanest, freshest meats . . . the youngest, freshest vegetables —all trimmed, cooked, and pureed with the greatest care—make Swift's Meat Dinners nutritious, easy to digest.

Swift's new Meat Dinners provide another fine way to include the important values of meat in the infant diet. You can recommend Swift's Meat Dinners for Babies with confidence. 5 varieties: Beef, Chicken, Ham, Veal and Lamb. (Most are also available in chopped form for Juniors.)

OTHER MEATS FOR BABIES FROM SWIFT . . .

Beef • Lamb • Pork • Veal • Chicken • Chicken & Veal • Ham • Liver • Liver & Bacon • Beef Heart • Pork with Applesauce • Ham with Raisin Sauce • Lamb with Mint flavour • Egg Yolks • Egg Yolks & Bacon.

Swift

To Serve Your Family Better

on nursing, the first recognition ever accorded the women of Canada through this means.

Our gracious Queen recognized our national association when she extended Royal Patronage to the CNA.

The CNA sponsored a study tour for British nurses that brought to our shores a group of enthusiastic visitors whose gratitude is expressed through invitations extended to assist in plans for the Canadian Study Tour-Post Convention European Tour in 1960.

Rome and the ICN Congress enticed over 250 Canadian nurses to visit abroad. Applications and arrangements for travel were all handled in CNA office. Already plans are developing for the 1961 ICN Congress in Melbourne, Australia.

Congresses and the increasing Exchange Privileges Program of ICN keep your National Office staff very much concerned with the interpretation of Canadian nursing to our colleagues from other countries.

Interpretation at the national level is accomplished by various means. The first Canadian Conference on Nursing brought together over 100 participants from related health and welfare agencies, government business and women's organizations. Some provincial associations have already held similar conferences at provincial level. Future national conferences are planned.

The Canadian Joint Committee on Nursing, representative of the medical, hospital and nursing associations, is a continuing body which keeps these three groups alerted to developments in each field.

Briefs presented by CNA to Royal Commissions and to the Dominion Council of Health have led to such invitations as the one to participate in the meeting of the Advisory Committee on Hospital Insurance on November 5 & 6 of this year. Here CNA representatives will discuss the subject of financial assistance for nursing education.

CNA members are being kept aware of developments through both English and French issues of *The Canadian Nurse* — the latter a recent achievement in Canadian nursing. The Readership Survey of our national magazine conducted by the Committee on Public Relations permitted a cross-section of our membership to offer suggestions for the improvement of this major tool of communication.

Publications prepared and distributed from CNA office continue to increase in number as do requests for these.

The films on nursing, "Student Nurse" and "The Hands That Heal," so long needed in Canada and produced by the National Film Board and Department of Immigration with our close cooperation, have proven excellent recruitment tools.

In order to improve and maintain high standards of service to our membership the staffs of your provincial and national offices have planned Annual Institutes designed to meet their particular needs. The second such Institute, was held last September.

This is but a brief glimpse and review of the developments and achievements of the past five years. It has been an exciting period in CNA history. It has been a privilege to be a part of this history. To the many nurses whom I have met through correspondence, through visits to your provinces and through committee meetings, may I express thanks and continued success in your work. To the staff of *The Canadian Nurse* — no more deadlines! But it was a pleasure to work with you in spite of the deadlines. To the staff of National Office my sincere thanks for five years of exceptionally interesting professional experience, and pleasant companionship.

A recent survey showed that in North America ethical drug manufacturers spent $9.00 in research for every $10 paid in dividends to shareholders.

— Canadian Medical Association Journal

Facts are stubborn things.

— Alain René le Sage

* * *

Feeling sorry for ourselves is nearly as widespread an illness as the common cold.

NOW... 3 NEW SOURCES OF VITAMIN-C FOR BABIES

EXCLUSIVE GERBER FRUIT DRINKS

Strained Orange-Apple, Orange-Banana and Orange-Apricot. All 3 have a guaranteed high vitamin-C content—40 mg. of crystalline ascorbic acid added per 100 c.c. Minimal peel oil insures digestibility.

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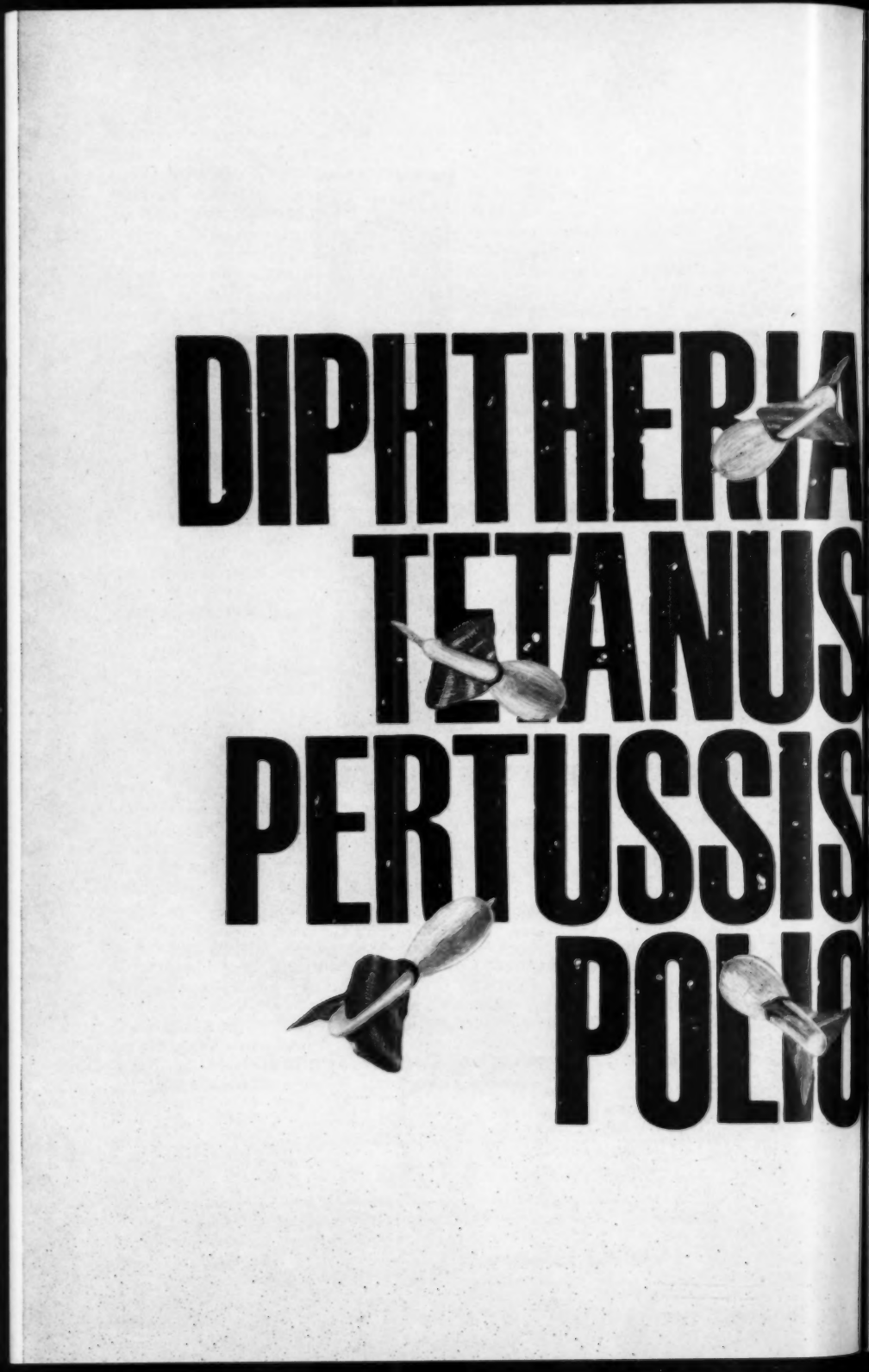
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*Barnett, C. D., Jr., *et al.*: *J.A.M.A.* 167:1103, 1958; and Am. J. Pub. Health 49:644, 1959.

Parke, Davis & Co., Ltd.
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65459

Revised Itinerary

CANADIAN NURSES' ASSOCIATION

1960 EUROPEAN TOUR

Sat. June 25 — ***HALIFAX*** Leave by morning plane via Gander for Prestwick.

Sun. June 26 — ***PRESTWICK*** Due to arrive. Continue by motor coach via the Trossachs to Edinburgh.

SCOTLAND

Mon. June 27 thru Wed. June 29 — ***EDINBURGH*** Arrangements will be made by the CNA for one day's professional observation visits to hospitals. (Transportation not provided by Thos. Cook & Son)
Ample time will be allowed for independent sightseeing visits in and around Edinburgh.

Thu. June 30 — Leave Edinburgh by morning plane via London for Paris.

FRANCE

Fri. July 1 to Sun. July 3 — ***PARIS*** Morning tour of the city by motor visiting the Louvre Museum, through the Tuileries Gardens and along the Champs Elysees to the Arc de Triomphe and the Unknown Soldier's Tomb, thence to Les Invalides (Napoleon's Tomb.). Return via the Place de la Concorde.
Afternoon tour of the city, passing the Bourse and Central Markets, visiting the Palais de Justice, thence to the Left Bank, past the Luxembourgh Gardens and Palace, to the Cathedral of Notre Dame, returning via the Place de la Bastille.
Late afternoon cruise on the Seine by "Bateaux Mouches," passing the Isle de la Cité and other points of interest. Dinner at the Eiffel Tower Restaurant.
Afternoon drive to the splendid Royal Palace of Louis XIV and the beautiful gardens at Versailles.
Leave Paris in the early afternoon by "Le Mistral" Express for Nice, arriving in the late evening.

Mon. July 4 — ***NICE*** Afternoon excursion via Gorges du Loup to Grasse.
Visit a perfume factory.

Tue. July 5 — Leave Nice by motor coach via the French and Italian Rivieras for Genoa, and continue by night train to Rome. Sleeping-car accommodations provided.

ITALY

Wed. July 6 thru Fri. July 8 — ***ROME*** Morning drive visiting the Vatican with its Museum, the Raphael Rooms, the Sistine Chapel and the Villa Borghese.
Afternoon drive visiting Piazza Venezia, Square of the Capitol, Roman Forum, Colosseum, Church of St. Peter in Chains, Basilica of St. Paul Outside-the-Walls and Janiculum for a fine view of the city.

Sat. July 9 — Leave Rome by motor coach via Assisi and Perugia for Florence.

Sun. July 10 — ***FLORENCE*** Morning drive including the Medici Chapels, Cathedral, Giotto's Campanile, Baptistry, thence via the Piazzale Michelangelo to the Pitti Palace to visit the famous Gallery.
Afternoon motor tour of the city including the Palazzo Vecchio, Loggia Dei Lanzi, Uffizi Gallery, Canta Croce Church where Michelangelo, Galileo and Machiavelli are buried, the Protestant Cemetery where Elizabeth Barrett Browning is buried, thence to the beautiful village of Fiesole overlooking Florence and the Valley of the Arno.

Mon. July 11 — Leave Florence by early afternoon train for Venice.

Tue. July 12 — ***VENICE*** Morning sightseeing stroll visiting the Church of St. Mark, the Doge's Palace, the Dungeons and the Bridge of Sighs. Thence by motor boat across the City and Lagoon, passing the Island of St. Michele (Cemetery of Venice) to Murano, where one of the principal Glass Blowing Factories will be visited.

Wed. July 13 — Leave Venice by day train via Milan for Geneva.

SWITZERLAND

Thu. July 14 and Fri. July 15 — ***GENEVA*** Tour of the city and planned professional visits to the World Health Organization, League of Red Cross Societies and other points of interest, through the courtesy of Miss Lyle Creelman, Chief, Nursing Section, World Health Organization, and Miss Yvonne Hentsch, Director, Nursing Bureau, League of Red Cross Societies. (Transportation for sightseeing in Geneva not provided by Thos. Cook & Son)

Sat. July 16 — From Geneva, continue by train to Lucerne.

Sun. July 17 and Mon. July 18 — ***LUCERNE*** Afternoon excursion by motor and cable-car to the summit of Pilatus. Return by cog-wheel railway and steamer via Alpnachstad.

Tue. July 19 — Leave by train for Innsbruck, thence by motor coach to Oberammergau.

GERMANY

Wed. July 20 — ***OBERAMMERGAU*** Attend the Passion Play.

Thu. July 21 — Leave Oberammergau in the morning by motor for Munich. After a short city drive, continue by afternoon train to Wiesbaden.

Fri. July 22 — Leave Wiesbaden by Rhine Steamer for Koblenz; continue by afternoon train to Brussels.

BELGIUM

Sat. July 23 — ***BRUSSELS*** Short tour of the city visiting the Bourse, Town Hall, Fountain Boy, Palais de Justice, Royal Museum, Parliament and Sainte-Gudule Church.

Sun. July 24 — Leave Brussels by morning train for Amsterdam.

HOLLAND

Mon. July 25 — ***AMSTERDAM*** Morning drive around old and modern Amsterdam, including the Royal Palace, Rembrandt's House, Portuguese Synagogue, Nieuwe Kerk, Oude Kerk and Stock Exchange, and visit to the Rijksmuseum and one of the diamond-cutting workshops.
Afternoon drive to the picturesque fishermen's village of Volendam and by boat to the isolated Isle of Marken where old Dutch costumes and customs are proudly maintained.

Tue. July 26 — Leave Amsterdam by early morning plane for London.

ENGLAND

Wed. July 27 thru Sat. July 30 — ***LONDON*** Three days will be planned for observational professional visits including visits to the International Council of Nurses Headquarters, the Royal College of Nursing, hospitals and health agencies, according to the wishes of the nurses. (Transportation arrangements not provided by Thos. Cook & Son)
On Friday, July 29, Thos. Cook & Son will provide a motor coach for a drive to Oxford for a visit to two of the hospitals — arrangements for the hospital visits to be made by the CNA.
There will be time available for independent sightseeing arrangements.

Sun. July 31 — Leave London by plane for Halifax and Montreal.

Mon. Aug. 1 — Arrive Halifax and Montreal.

Approximate Tour Fare — $1,270.00
All fares are based on tariffs and exchange levels existing July 21, 1959, and are subject to change.

The Tour Fare includes

Transportation in Europe in first class compartments on Continental trains, with reserved seats wherever obtainable. Berth in double sleeping compartment for overnight travel. First class on local steamers. Private motor coach where motor coach transportation is specified.
Hotel accommodations based on sharing a twin-bedded room without private bath at ordinary first class hotels. There will be a limited number of single rooms, without private bath available at a supplement of $83.
Meals: Three meals daily throughout the tour, namely, meat breakfast and table d'hote lunch and dinner, with the exception of Edinburgh, London and Paris where breakfast only will be provided.
Sightseeing: Complete program of sightseeing with experienced local guides, including the major places of interest and many others as outlined in the itinerary.
Transfers of passengers and two pieces of hand baggage between airports, railway stations, hotels, etc., from arrival Prestwick around to departure London. Weight of baggage will be limited to 44 lbs. because of air travel and charges for excess must be paid by passengers direct to the air line.
Tips or fees to hotel servants, porters, chauffeurs, etc., to the extent of the services included in the tour fare, also admission fees during all sightseing trips arranged by the Tour Escort.
Taxes on travel and hotel accommodations within Europe as at present imposed by the European governments, with the exception of local airport taxes.
Tour escort to accompany the tour to take charge of all travel details from arrival Prestwick around to departure London.
Services of Cook's staff in planning and operating the tour.
The fare does not include expenses of air transportation; local airport taxes; lunches and dinners in Edinburgh, London and Paris; after-lunch and after-dinner teas or coffees; food not on the menus of the included meals; laundry, wines, mineral waters or other personal items; and items not listed as being included in the tour fare.
Baggage insurance, which is strongly recommended but not included in the tour fare, may be purchased when final payment is made for the tour.

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Erythroblastosis Fetalis

E. Rutledge

Once, in approximately 400 pregnancies, the Rh factor is responsible for a chain of events that may prove harmful to the fetus. There is a series of predisposing factors which must be combined before the Rh substance will exert a harmful effect on the unborn infant:

1. The mother must be Rh negative.
2. The father must be Rh positive.
3. The fetus must be Rh positive.
4. The Rh substance from the fetus must enter the mother's blood stream where antibodies are built up against it. These then, pass through the fetal blood stream where they cause varying degrees of damage to the red blood cells of the fetus.
5. The mother must have had a previous pregnancy, or a transfusion of Rh positive blood, and have built up antibodies to the Rh substance.

Because only 15 per cent of the white population is Rh negative, there is only one chance in seven that the mother will be of this type. The chances are six out of seven that the father will be Rh positive, but about half of the male population is partly Rh negative. The outcome will largely depend then, on whether the father is homozygous (spermatozoa all Rh positive) or heterozygous (spermatozoa half Rh positive and half Rh negative). If he is heterozygous there is a 50-50 chance that the infant will be Rh negative and therefore have no Rh substance to which the mother will build up antibodies.

If all of the predisposing factors occur the result may be erythroblastosis fetalis, a disease that affects the bloodforming organs of the newborn. This disease is responsible for about 3 per cent of all fetal deaths and may be evident in one of three forms:

1. *Hydrops fetalis* — the baby is tremendously edematous and invariably dies.
2. *Icterus gravis* — the infant is jaundiced and anemic at birth, the jaundice deepening progressively. Many of these babies may be saved with repeated blood transfusions.
3. *Congenital anemia* — the infant has a marked anemia with consequent pallor. Blood transfusions may save a certain number of these infants.

Miss Rutledge is a recent graduate of Galt Hospital, Lethbridge, Alberta.

Baby Diane

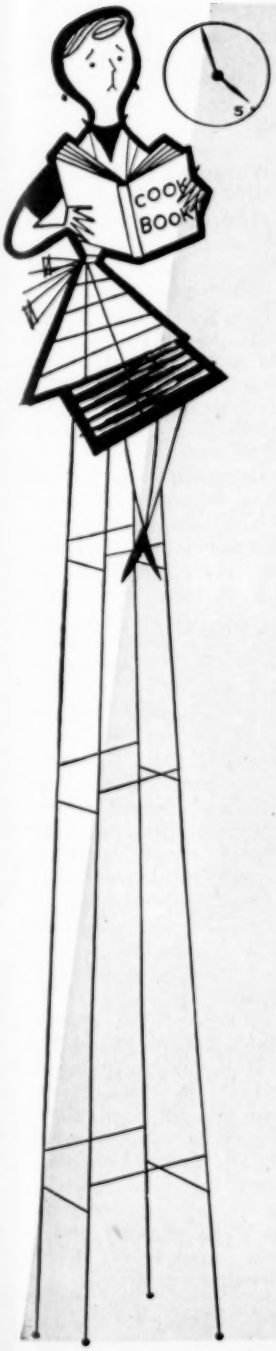
Baby Diane was born into a family of four sisters and brothers. Her arrival presented no problem to her or to her mother. Her first cry was spontaneous, she was suctioned in order to maintain a good airway and was placed in a prewarmed incubator. Her eyes were treated with silver nitrate drops, followed by sterile water. This is a prophylatic measure to prevent ophthalmia neonatorum and possible resultant blindness. Baby Diane was then identified with a wrist bracelet. Because of her mother's history, blood specimens were taken from the baby for the purpose of testing her hemoglobin, hematocrit, differential and serum bilirubin. The results confirmed the need for an immediate transfusion. Baby Diane was given an exchange transfusion of 250 cc. of blood.

Routine for Exchange Transfusion:

1. The blood should not be over four days old.
2. Heat it to 95°F. (½ - ¾ hr.)
3. The baby should be cleansed with aqueous zephiran and well-wrapped, including hot water bottles.
4. Two or three assistants are necessary:
   a) one at the baby's head to give continuous oxygen, to suction if necessary using a metal tip and to keep a constant check on the axillary temperature.
   b) one is responsible for recording amounts of blood administered and withdrawn.
   c) one remains with the physician in charge to care for syringes, etc.
   d) the cord should be tied so that it is two to three inches in length.

Procedure for Baby Diane

A sterile polyethylene catheter was threaded through the umbilical vein



THIS little housewife had a problem — sweet-tooth Hubby on a sweet-free diet. (And beginning to get nervous about it.) She tried everything. Fancy salads. Bigger helpings. But Hubby's frown darkened by the day. Then one day she read in a magazine about a discovery, a new non-caloric sweetener. One that she could actually cook and bake with — in any food, at any temperature. One which gave the perfect taste of sugar — with no bitter aftertaste in ordinary use. That night there were cookies, pudding, coffee — *sweet* coffee — and a big, big smile across the table . . .

Abbott

. . . and so she started using

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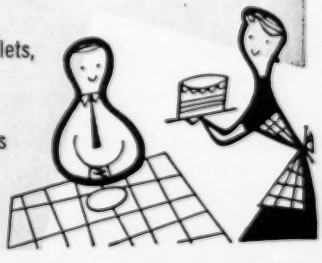

toward the liver. The venous pressure was checked. Normal is 6 cm., Baby Diane's was 10 cm. No air was permitted entry into the circuit. Using a three-way stop-cock, 10 cc. of the baby's blood was removed and replaced with 10 cc. of the whole blood. This procedure was continued, using 10 cc. each time, until 250 cc. of blood had been given.

Calcium gluconate was given via the umbilical vein in order to counteract any possible reaction. Baby Diane had no reaction to the transfusion but began to fidget and vomit, so calcium gluconate was given at intervals up to a total of 5 cc. If too much blood is administered, there may be evidence of heart failure.

On completion of the transfusion her venous pressure was 2 cm. Blood plasma, 10 cc., was given and a specimen of blood withdrawn. The catheter was removed and the cord ligated.

Complications of Transfusions:

Anemia may occur in about three months, which again may be controlled by transfusion.

Infection at the umbilicus is a less common complication.

Initial Nursery Care

Baby Diane was taken to the premature nursery in an isolette. Oxygen was administered at three litres per minute and she was watched carefully. She was bathed and cleansed with Phisohex, then weighed and measured. As the average baby of 40 weeks gestation weighs six and a half to seven and a half pounds, she was nearly a pound underweight since she weighed only five pounds, eleven ounces. She was 20 inches in length, 13 inches head circumference, 12 inches around the chest. The normal baby usually has a head and chest circumference of equal or nearly equal measurement.

Her extremities were blue but this is normal at birth, the circulation not being as fully developed as it will be. Her color changed from pale pink as she became increasingly jaundiced. This usually denotes an increase in the serum bilirubin of an infant with erythroblastosis fetalis. During her first day of life red blotches appeared on her arms, legs and chest. As each group faded new patches would appear in other sites; this continued for three days. The jaundice increased for three days, then began to recede.

Daily Nursing Care

Baby Diane remained in the isolette, and warm aqueous zephiran (1-1000) compresses were applied to her cord q.4.h. In between, her cord was kept soft with normal saline compresses in case it became necessary to give her further transfusions. Her temperature was taken daily. It ranged from 96° - 98°F. which was normal, as it should be maintained at a level above 96°F. She received nothing by mouth for the first 12 hours following birth, because of the usual amount of mucus present.

During her second day she was fed sterile water to maintain her fluid balance. She had lost three ounces which is characteristic of newborns. On her third day she was given lactose q.4.h. and gained back one ounce. The following day she began a milk regimen. By the time she was ready to go home she weighed 5 pounds and 14 ounces.

Baby Diane's daily care included a bath, taking her temperature and a close check on the amount and color of her urine and stool. On the third day her urine was a bright yellow-orange, characteristic of the loss of bile pigment. She passed several liquid yellow to green stools and a few brown stools. She had a Phisohex bath every third day and the anal and vulvar regions were kept clean and dry.

Health Teaching

Baby Diane's mother was encouraged to care for her baby as she had done for her other children in regard to sleeping and eating habits. It was explained to her that the condition of her baby was good but that it would be necessary for the baby to have blood tests at various intervals. Usually, special care to the cord is necessary, but Baby Diane's had fallen off, and so the mother was asked to watch the healing process with care.

There are truths which are not for all men, nor for all times. — VOLTAIRE

When time is short and the need is great,
the bright refreshment and quick lift
in Coca-Cola seem delightfully welcome.

Another Reason for Hope

GENEVIEVE LAMARRE, B.Sc.

WHEN a group of nurse educators, who are qualified in their specialty, become anxious about their teaching methods, it astonishes us. And yet, they are not merely preoccupied, but also anxious to find solutions to their problems. Their solution was summed up in a request to the Marguerite d'Youville Institute for the organization of a conference for the purpose of revising the methods of teaching chemistry, the cause of their anxiety. A leading centre for the teaching of advanced nursing in Montreal, the Marguerite d'Youville Institute willingly granted their request.

As soon as the academic year in schools of nursing was ended, educators from many centres formed a group under the direction of Sister Rose LaCroix, a professor at the Institute. Their aim was to analyze the teaching program in chemistry and through reorganization, to plan details of a new arrangement of courses. Was this all? One more point! Practice and theory are not to be separated. These nurses, many of whom live 500 or more miles away from each other, gathered together in lively sessions for an 8-day intensive workshop. All talked the same language, were animated with the same ideal — educating nurses adequately to meet the needs of our times.

The *who, what, why, when* and *how* formed the theme for the workshop.

Who? Students, on entrance to a school, should have acquired the elements of chemistry; otherwise the school must teach them before embarking on the program as outlined.

What? The course in biochemistry is a continuation of introductory chemistry and explores thoroughly the facts that are necessary for the formation of scientific knowledge in nursing.

Why? Chemistry is the science from which most of the subject matter in nursing is drawn: nutrition, microbiology, pathology, nursing arts and health. Everything is interrelated. A further reason, this discipline promotes thought and logical reasoning, and in a sense, forecasts the consequences of actions.

When? Obviously, this course is given early in the preclinical period in conjunction with allied sciences, since it is a prerequisite to the understanding of them and a necessary concomitant to them.

How? Chemistry may be taught by a variety of methods: theory, demonstrations, experiments, films, slides, and finally study tours, etc.

With the principles before them, the group proceeded to the selection of important items. In order to try to foresee the practical organization of materials, a plan was drawn up that included a list of chemical substances and a variety of solutions. Notes were made of points that could be useful as a guide for practical experience. Next came visits to three laboratories: one large and modern, the second, older, but well-equipped, and the third an ingenious modern structure that had limitless resources.

Being laboratory technicians in their schools, three of the nurses in the group felt at home in these surroundings, and on the spot became professors. And what professors! Their colleagues of the workshop now became their pupils. They were grateful for the teaching, profited by the demonstrations and took part in the experiments. In a word, they were happy to tap the resources of their colleagues.

The cold and exacting atmosphere of science was permeated by a conspicuous air of cordiality. There was only one *explosion* — one of joy, at the very last minute as farewells were being said, because the faculty agreed to the requests of the participants for other study sessions. Each nurse wrote on her note pad, "to be continued." What conclusions? There is a stir in nursing. Teaching of the sciences had become more meaningful. Chemistry

Miss Lamarre is the director of nursing education at l'hôpital de l'Enfant-Jésus, Quebec City.

Who will help Clementina?

This is Clementina. Italian, age 5. Home is a hut; no gas, no running water, no toilet. The floor is beaten earth. One bed for the family. Blankets are dirty rags and clothes gathered together at the end of the day . . . every day. The kitchen is a rudimentary fireplace. Clementina has not yet gone to kindergarten . . . this will be next year. A child who never owned a toy . . . who knows not how to play . . . she gathers wood for fuel in the nearby woods, does the family washing in the public lavatory, looks after her mother and father who are ill and her younger brother. Her parents look with anguish at their child who never smiles. For Clementina, hunger is never appeased, misery deep. Burdened beyond her years, her sad bewildered eyes tell the story of her wretchedness. Help to this family means hope instead of despair . . . a chance to live.

You, alone, or as a member of a group, can help these children by becoming a Foster Parent. You will be sent the case history and photograph of "your" child upon receipt of application with initial payment. "Your" child is told that you are his or her Foster Parent. All correspondence is through our office, and is translated and encouraged. We do no mass relief. Each child, treated as an individual, receives food, clothing, shelter, education and medical care according to his or her needs.

The Plan is a non-political, non-profit, non-sectarian, independent relief organization, helping children in Greece, France, Belgium, Italy, Western Germany, Viat Nam, and Korea. International headquarters is in New York. Financial statements are filed with the Montreal Department of Social Welfare. Full information is available to any competent authority. Your help is vital to a child struggling for life. Won't you let some child love you?

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I enclose herewith my first payment $.....

B. I cannot "adopt" a child, but I would like to help a child by contributing $.....

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Contributions are deductible from Income Tax.

acquired some new friends. A sense of responsibility had resulted in a new orientation of thought. There was an awakening to the necessity of sharing ideas in a true team spirit and all humility. Who, then, can but gain success?

When nursing educators, conscientious about the tasks they take on, assert themselves and take refresher courses during their vacations, the nursing profession has "another reason to hope" for the betterment of the society that they serve.

Involutional Melancholia

JOHN GIBSON, M.B., CH.B., D.P.M.

INVOLUTIONAL melancholia is a particular form of depression occuring at the involutional period, which is taken to be from 40 to 55 in women, 50 to 65 in men. It is a time of failing mental and physical powers, of retirement, of reflection on lost opportunities, of fears of illhealth, poverty and death. Although some degree of sadness, uncertainty and anxiety may characterize many people at this time, only a few develop a frank psychosis. From the depressive phase of a manic-depressive psychosis, an involutional melancholia differs in three main particulars: the personality and physical types of the person affected, the characteristics of the illness, and the prognosis. It is quite possible for a depressive phase of a manic-depressive psychosis to develop for the first time during the involutional period and to be mistaken for an involutional melancholia. It is not always easy to be certain of the diagnosis, either because the symptoms are not clear enough or because of a history of a possible breakdown, depressive or manic, earlier in life.

The precise cause of the disease is unknown. The patient may show evidence of arteriosclerosis or other degenerative disease, but not always so, and it is not always people in poor health that develop the disease. An attack may be precipitated by an illness, the occurance of a hernia, or an operation. Psychological factors may be: retirement, financial restrictions, loss of power and position, unfulfilled ambitions, and fears of uselessness, loneliness, and unwantedness. But the illness may occur in people whose future is reasonably assured, who have ample money and work still to do.

Unlike the manic-depressive patient who is usually a *pyknic* the patient with involutional melancholia does not present any typical physical build. His prepsychotic personality is usually quite distinctive. He has been the hard-working, conscientious, God-fearing, church-going man; he has lived a quiet life, he has saved money, he has been provident and careful; he has not been given to excesses; his life has been one of steady work, sometimes carried to an obsessional degree. He has not had the mood-swings of the manic-depressive; his life has been one of rigidity and emotional repression; he has been one of the pillars of the society in which he has lived — the reliable solicitor, the steady workman, the conscientious bank manager, the careful clerk. Female patients are of the same type.

The onset of the illness is usually slow, with the early symptoms of anxiety, peevishness, vacillation and unhappiness arising so imperceptibly out of the patient's previous personality that it is not easy to say precisely when his condition became abnormal. From these early symptoms he progresses into the full development of the disease.

When the disease is fully developed the patient's depression is extreme. He has ideas of unworthiness, misery and utter hopelessness. Characteristically he entertains a number of ideas of an absurd and fantastic character — such as that he has no brain, it has

Dr. Gibson is a psychiatrist at St. Lawrence's Hospital, Caterham, Surrey, England. This is the third of a series of articles on psychiatric subjects.

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turned to sawdust; he has no heart; he has no stomach or bowels, they have rotted away, they are immovably blocked up, no food can go through him, all the food he has ever eaten is still within him, he has no organs at all, he is a mass of putrefaction, he is riddled with syphilis or tuberculosis or cancer. He may believe that he is to be tortured forever, is to be smitten dead on the spot, is already dead, is never going to die, is to live a living death throughout eternity. He may refuse to eat on the grounds of utter worthlessness, inability to digest food, or complete blocking of stomach or bowel. He may suspect the food to be poisoned. He searches his past and often blameless life for the crime, misdemeanor or peccadillo that has caused this terrible punishment to fall on him, and may even go all the way back to some jam-stealing incident of his childhood.

In contrast to the depressive of the manic-depressive kind (who may take his depression quite calmly) the involutional melancholic patient is intensely anxious and agitated, pacing up and down, wringing his hands and lamenting his fate. He does not show the retardation typical of the other disease. With his insomnia, agitation and refusal to eat he may become physically exhausted.

Suicide is a constant preoccupation with him and a very serious danger, the importance of which cannot be over-emphasized. Mutilation may be attempted.

The length of this illness tends to be prolonged if untreated, and the prognosis is always graver than that of a manic-depressive attack. Admission into a mental hospital may be necessary for all but the milder cases for whom adequate care can be given at home. The application of ECT will often produce a dramatic change for the better. Usually, two or three treatments given weekly for several weeks will abolish the depressive ideas and cause the patient to become quieter, to eat and sleep well. Unfortunately this improvement cannot always be maintained and the patient may relapse into his former condition. Because of this tendency to relapse, a patient may be given several courses of ECT. Before the introduction of ECT it was not unusual for an attack to last several years. Even after that length of time complete recovery was possible. For many patients the outcome of the disease is still in doubt, relapse is common. Although some recover, others, able to live at home, remain in a state of invalidism of varying severity. The results of prefontal lobotomy are unpredictable. On some it has a beneficial effect, some may have their depressive ideas reduced to a degree that enables them to live at home, and some have had their depressive ideas replaced by a state of chronic intractable excitement.

Nursing the patient in bed under strict observation is necessary during the acute stages of the illness. Emphasis in the nursing care must be placed on feeding, the care of the bowels, and the timely use of sedatives.

Actually a linen closet on wheels, the **Linenmobile** is a new product of Atlantic Alloy Industries and performs the multiple functions of loading, transporting, storing and distributing.

In the laundry loading room, Linenmobiles are stocked with clean linen in accordance with their labeled compartments which indicate type and quantity of each item required. Linen may be loaded from both sides, thereby hastening the operation. After loading, protective shades on both sides are drawn closed, and the Linenmobile is ready for transit to patient areas.

Each Linenmobile bears patient-area identification, and may be parked in linen closet or alcove, where it remains as a source of linen distribution. It is available in two standard models, with bed capacities of 20 to 25 and 30 to 35.

Atlantic Alloy Industries, Inc., Polk Street, Union, New Jersey.

* * *

Curiosity is one of the permanent and certain characteristics of a vigorous mind.

— Samuel Johnson

* * *

Liberality consists less in giving a great deal than in gifts well-timed.

— Jean de la Bruyère

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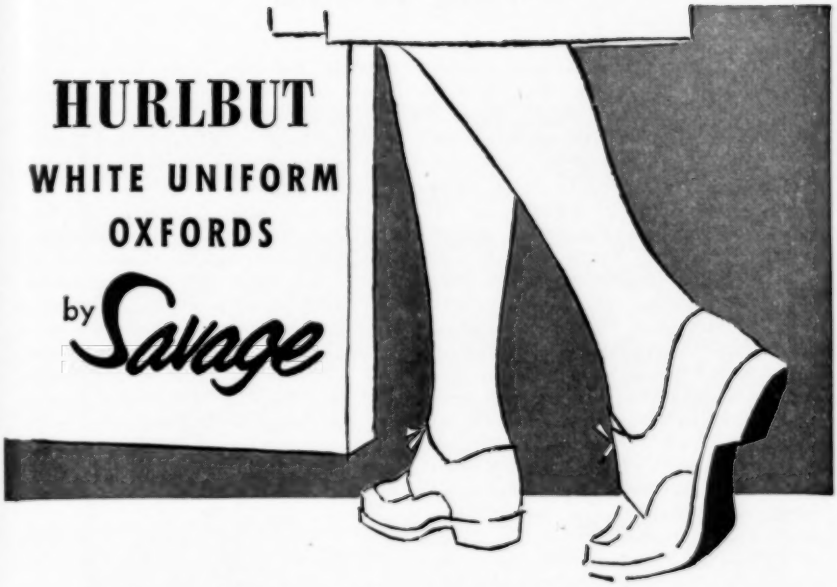

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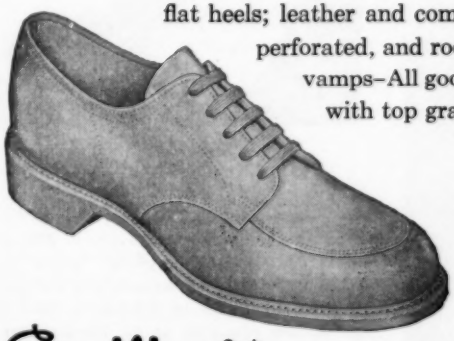

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Nursing Profiles

Verna Huffman, who has been a senior nursing counsellor of the Civil Service Health Division, Department of National Health and Welfare, is going on loan to the Pan American Sanitary Bureau of the World Health Organization. In her new position she will be a nursing consultant to the ministries of health of British Guiana, Barbados and Trinidad.

Miss Huffman's varied background ably fits her for her task. A native of Peterborough, Ontario, she graduated from Civic Hospital there, and received her diploma in public health nursing from University of Toronto. Her early public health nursing was with the Victorian Order of Nurses in Toronto, Guelph and Montreal. She has worked with underprivileged children through the Kiwanis Club of Toronto. As senior nursing counsellor, she has recently been working on a research project, the object of which was to improve the quality of the program of the nursing counsellor service in the Civil Service Health Division.

An interest of long standing in people of various cultures was further piqued during Miss Huffman's residence at International House in New York City, while she obtained her Bachelor of Science degree in nursing at Columbia University. She has been active in nursing association affairs at the local, provincial and national levels and now is going on to the international.

VERNA HUFFMAN

Fanny Kennedy, better known to her friends as "Nan," has joined the provincial office staff in British Columbia this month. She recently completed work on a Master's degree program at the University of Washington.

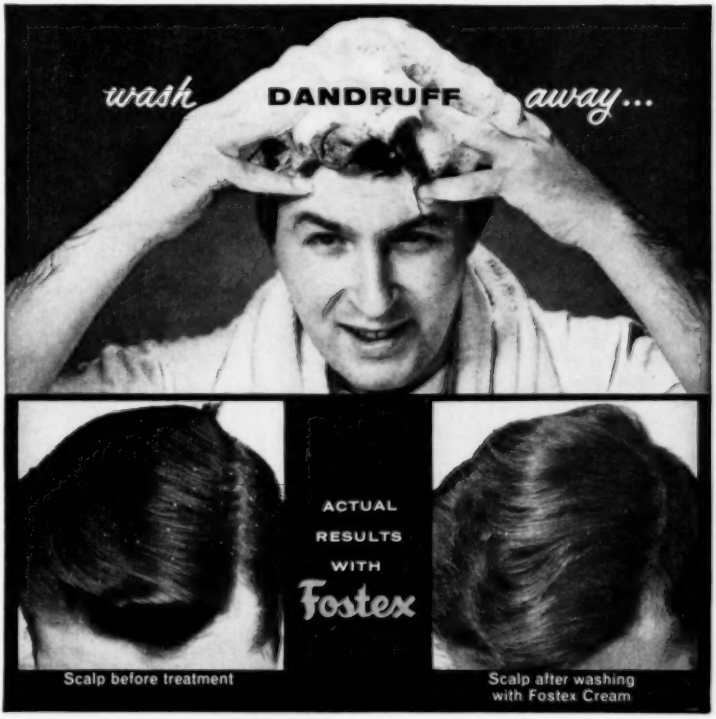
She is a graduate of the Vancouver General Hospital and the University of British Columbia. Institutional and private nursing occupied her for a time following graduation. This was succeeded by a number of years' service with the B.C. Department of Health prior to acceptance of an appointment with the World Health Organization. While working with WHO, Miss Kennedy saw duty in East Pakistan as a public health nursing tutor and in Teheran as a nurse consultant. She is to be educational consultant for the RNABC.

(Mulholland Studios)

FANNY ANN KENNEDY

The new president of the Saskatchewan Registered Nurses' Association is **Eleanor Louise Miner.** A native of Speers, Saskatchewan she attended Battleford Collegiate Institute then went to Alberta in 1934, for her nursing education at the Royal Alexandra Hospital in Edmonton.

Miss Miner has her public health nursing certificate from Toronto University, her B.N.



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(West's Studio)

LOUISE MINER

from McGill University and her M.P.H. from the University of Michigan. She gained experience in institutional nursing in Saskatchewan, Alberta and British Columbia, including two years as matron of the Bella Coola Hospital in northern B.C. In public health nursing she was a staff nurse in the Assiniboia region and rural Regina. Her public health posts in Saskatchewan have taken her to many parts of the province, as senior nurse in the Assiniboia, North Battleford and Prince Albert Health Regions. This experience ably qualified her for her present position as public health nursing consultant, a post that she has held since 1955.

She has ample qualifications for her new role as president of the SRNA having been chairman of the public health nursing section and first vice-president of the SRNA. She is also president of the Saskatchewan branch of the Canadian Public Health Association.

With such a busy schedule, Miss Miner finds relaxation in playing the piano and listening to music.

Sister Madeleine of Jesus has recently been appointed Director, University of Ottawa School of Nursing. Born in Haverhill, Massachusetts, she received her preliminary education there and in Plattsburg, New York. A graduate of the Ottawa General Hospital, Sister Madeleine returned to the U.S.A. to pursue a course in School Administration at St. Teresa's College in Winona, Minnesota. She later received her Bachelor of Science in Nursing Education at the University of Ottawa and in 1947 her Master of Science in Nursing Education from the Catholic University of America, Washington, D.C. Last year Sister Madeleine was awarded a fellowship in the American College of Hospital Administrators.

Before going to the University of Ottawa in 1952, as professor of nursing education, she was an instructor at her home school of nursing, Superior of St. Joseph's Hospital in Sudbury, director, nursing education, University of Ottawa, and director of the school of nursing of St. Joseph's Hospital in Lowell, Mass.

SISTER MADELEINE OF JESUS

Sister Madeleine is extremely active in nursing circles. She is now serving as a member of the advisory committees of the Victorian Order of Nurses, the St. John's Ambulance, on Conferences of the Registered Nurses' Association of Ontario, and on the Canadian Nurses' Association Finance Committee. She is a past president of the Alumnae of the Ottawa General Hospital and in 1958 was elected representative of the Ontario Nursing Sisterhoods to the CNA executive.

In August of this year, **Joan Stock** was made director of the department of graduate studies, of the University of Ottawa School

of Nursing. A native of Collingwood, Ont. she is a graduate of the Ottawa University School of Nursing.

HUGUETTE BARBEAU

Last June **Huguette Barbeau** was appointed nursing arts instructor at the Notre Dame Hospital in Montreal. She received her early education at the school of the Sisters of Ste Croix, taking arts and science, and on graduation took a commercial course at the same institution.

Before entering nursing she was employed for three years in a lawyer's office. Since graduation from Notre Dame Hospital in 1956 she has been clinical instructor in surgical nursing there. Immediately prior to her new appointment Miss Barbeau received her B.Sc.N. from Marguerite d'Youville Institute in Montreal.

During her high school years Miss Barbeau was active in student affairs. This enthusiasm for organized activities has since been applied to her alumnae association, the Catholic Nurses' Association and her local and provincial nurses' associations.

In her leisure time, Miss Barbeau enjoys reading, music and the theatre; she also finds time for her favorite outdoor sports — skiing and horse back riding.

The weary listlessness, which renders life unsupportable to the voluptuous and the indolent, is unknown to those who can employ themselves by reading.

— FÉNÉLON

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In the Good Old Days

(The Canadian Nurse — November, 1919)

Here are some of the resolutions presented at the National Conference on Canadian Citizenship:

"That immigrants having non-British names be required to change their spelling or adopt new names in order that none might know their original origin."

"That a Canadian Citizens' Education Association be formed with executive officers and membership fees, to perpetuate the work begun in the Conference."

* * *

It seems wise to define the term ethics "as the ability to choose between right and wrong." There are all sorts of circumstances and conditions which control the motive for the act, and it is an extremely difficult thing to lay down accurately the correct response for each situation which presents itself.

"Ethics" have been formulated and maintained by the character and individuality of the group in the broader social sense. Their origin began with the prehistoric people, who were controlled by a brute force issuing from the individual possessing the stronger personality. Slowly this code of social ethics has developed.

The influences which have affected this growth may be classified under the heading of an ideal. From this beginning has evolved the religious ideal, the ideal in regard to self, and, most important, these are being based upon the conception of a state which could best serve human development.

The ideal in regard to self applies itself most readily to the application of ethics in the profession of nursing, as from it emerges the conception of a highly reflective life, its character and responsibility. We might justly say that ethics are based upon the development of conscience, an established standard by which acts are judged.

By checking the blood pressure of the eyes, one cause of stroke can be diagnosed even before the stroke occurs, according to a group of Boston physicians. A common cause of paralytic stroke is the clogging of the internal carotid artery, which leads through the neck to the brain. If an obstruction, such as a blood clot, is found in the artery early enough, it can be removed by surgery or the use of clot-dissolving drugs, thus preventing a stroke.

Internal carotid artery insufficiency can be diagnosed by checking the blood pressure of the eyes. It is measured by the technique, called ophthalmodynamometry. In the procedure, the eyes are first dilated and anesthetized. Pressure is applied to the eyeballs and the blood pulsations are observed through the ophthalmoscope.

The technique is rapid and safe. It is becoming increasingly important with the recent advent of more effective treatment of carotid artery insufficiency. In addition to its use as a diagnostic procedure, the technique can be used to check the effectiveness of treatment for carotid artery obstructions.

It should be used as a diagnostic procedure whenever patients exhibit such early signs of carotid artery obstruction as transient partial blindness, dizziness or nausea on changing posture, or weakness of the limbs on one side of the body.

— *The Health Bulletin*, North Carolina State Board of Health.

* * *

The customs which have evolved about drinking of tea contribute to the cultivation of an art too far lost in modern America — the art of being relaxed while fully conscious. They contribute to the enjoyable experience of finding oneself socially accepted by people who are quite sober. They encourage courteous and lively discussion in an atmosphere of mutual respect. Such customs have a social and mental hygiene value not to be underestimated.

* * *

The services of a good teacher will never be actually evaluated. When a community employs one it is buying the moral and mental outlook of its children, buying ideals, attitudes and appreciations that will do more to determine the success of its children than mere mastery of subject matter important as this is. — D.R. MacLelland

Babies have to pass exams too!

And in these regular medical check-ups, Farmer's Wife babies get top marks for steady weight gains and few, if any, feeding upsets. This is no surprise to the medical profession, because the five different Farmer's Wife Infant Formula Milks make it easy to prescribe for each baby's individual dietary needs.

Besides the well-known Whole, Partly Skimmed and Skimmed Milks, now Farmer's Wife introduces two new Instant Prepared Formulas (Red Band—Whole Milk; Blue Band—Partly Skimmed Milk). These are another Farmer's Wife "first", the only evaporated milk products to incorporate a stable form of Vitamin C. Since the carbohydrate is already added, new Farmer's Wife Prepared Formulas eliminate the chance of contamination or error in formula preparation, and save mothers time, trouble and expense.

All five Farmer's Wife Formula Milks are Vitamin D increased. All are vacuum packed in modern, enamel-lined cans; stock rotation ensures absolute freshness. Available at all grocery and drug stores.

Farmer's Wife

Prescribed by many doctors—
Approved by wise mothers

Diabetic Ketosis

Doris (Haave) Dahl

The Patient as a person

The saying that everything from Texas is bigger than from anywhere else seemed true of Mr. Hood. Born and raised in Texas, at 57 he was six feet five inches tall, and weighed 190 pounds. In 1930 he came to Canada but had never bothered to obtain his Canadian citizenship papers. He had been a healthy man most of his life and was employed for several years as a machinist with a fisheries company. Mr. Hood had no relatives in Canada.

On admission to hospital he looked untidy but as his condition improved he took much more interest in his personal appearance.

He did not seem to have formulated many ideas on religion or a philosophy of life and he took an impersonal and pessimistic attitude toward world affairs. He was pleasant to converse with and clearly appreciated the help that was given him. His adjustment to the hospital was fairly good in regard to cooperation with staff, although at times he was antagonistic and stubborn. If the nurse was firm and proceeded with her work he did nothing to stop her, realizing that she knew what she was doing. Instead of chatting with the other patients in his 10-bed ward he read or dozed most of the day. Toward the end of his hospital stay he became more sociable.

The Condition

Ketosis is a complication of diabetes mellitus. Diabetes mellitus is a chronic metabolic disorder in which the body is unable to utilize glucose due to the failure of the pancreas to secrete insulin in sufficient quantity. There is a definite hereditary predisposition though the condition may remain dormant for some time.

Mrs. Dahl, now a graduate of the Royal Columbian Hospital, New Westminster, received Honorable Mention and a book in the Macmillan Award competition.

Normally, insulin is secreted by the Islands of Langerhans in the pancreas. It is necessary for the utilization of glucose by the tissue cells, transporting the glucose through the cell membrane. When there is a deficiency of insulin the glucose that is absorbed from the gastrointestinal tract is neither stored nor utilized because it cannot get inside the cell. Instead, it accumulates in the circulating blood. The kidneys allow it to overflow into the urine when it reaches the renal threshold, which is the level at which glucose is absorbed by the afferent vessel into the kidney.

Ketosis is a complication in which the acid-base balance of the body is upset. Ketone bodies, such as acetone, diacetic acid, and beta-hydroxybutyric acid, are products of incomplete fat oxidation. In severe diabetic acidosis most of the ingested carbohydrate and the sugar from protein is lost in the urine. Thus there is an increase in fat and protein breakdown in order to meet the body's energy requirements. Being acid, these ketone bodies must unite with a base, such as sodium, but in so doing they use up the alkali reserve of the body and acidosis results.

In the kidney, ammonia which is normally converted into urea, is substituted for the sodium to prevent its loss. The amount of ammonia excreted in the urine is greatly increased and the amount of urea is greatly decreased. If ketosis is severe the ketone bodies are formed so rapidly that the supply of ammonia is insufficient. The ketone bodies collect in the body fluids and are excreted in the urine and expired air. This explains the acetone smell of the breath and the presence of acetone in the urine.

Signs and symptoms of ketosis: Weakness and fatiguability, flushing of the skin resembling sunburn followed by pallor, and acetone odor of the breath are significant symptoms. Acetone odor is sweet and heavy, similar to that of an overripe apple.

The extremities may be cold and purplish due to reduced peripheral blood

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flow. As acidosis increases, weakness progresses and respirations increase in rate and depth. Abdominal symptoms such as epigastric pain, nausea and vomiting may make it difficult to distinguish this condition from appendicitis or pancreatitis. A large amount of fluid is excreted as urine in an attempt to dilute the sugar and electrolytes. This, in combination with vomiting results in dehydration which is characterized by thirst, a parched tongue, dry skin, and soft eyeballs.

The temperature is slightly above normal. The white blood cell count is often as high as 25,000 cells per cubic milimeter. A reliable clinical indication of the severity of the condition is a decrease in the carbon dioxide combining power of the blood plasma.

Prevention of diabetic ketosis: To prevent an upset in the acid-base balance of the body one must keep a proper balance between the diet, insulin, and exercise. If any one of these is decreased or increased in comparison to the others the symptoms tend to appear.

The diet must be sufficient to attain and maintain the desired weight for the individual. Obesity must be prevented or overcome. Unusual *quality* of exercise rather than *degree* of vigor causes a temporary shortage of glucose in the body, therefore extra carbohydrate should be taken before extra exercise. The diabetic patient should have at least one-half hour of active outdoor exercise daily at a regular time. Normal exercise lowers the amount of sugar in the blood so that less insulin is needed.

Infections must be prevented by good personal hygiene and by immediately reporting any break in the skin to the doctor. Respiratory and other infections should be reported to the doctor at the first symptom before they increase in severity. Fever decreases food tolerance and inhibits the action of insulin, thus raising the requirement for it.

Past History

Mr. Hood had been a diabetic for 17 years but he could not recall any other diabetic among his relatives. He had had previous hospitalizations for treatment of acute cholecystitis and bursitis of his right shoulder.

His diabetes had been regulated on 70 units of Isophane insulin daily without any special diet regulation except the omission of sugar. He had not restricted his caloric intake but was accustomed to eating lightly. Every few days Mr. Hood had mild insulin reactions from such a high dosage of insulin in comparison with the moderate amount of food that he was taking. He simply increased or decreased the insulin dosage as he found it necessary.

About one week prior to this admission he injured a finger while at work, gashing it down to the bone at the knuckle. He made a splint of a strip of aluminum and the company doctor applied it with elastoplast and sent him home. Following the accident he had anorexia and vomiting. He ate and drank very little and totally dispensed with his insulin.

Eventually he became so weak and sick that he could not think sensibly enough to call a doctor. He had obtained some pills containing codeine to relieve his headache. Living alone, he had no responsible person to care for him. Instead, some of his well-meaning friends brought beer and ale to cheer him up and to bring back his appetite. His condition became increasingly worse until finally someone called a doctor.

Present Illness

On admission to hospital the anorexia and vomiting persisted. Mr. Hood's face was flushed and he was in a mild state of dehydration. He was weak and irritable. His pulse rate was 88 and of good quality. His breath smelled of acetone. The result of the Clinitest for sugar in the urine was plus one and the acetone content was moderate. The next day the nausea persisted until a Levine tube was inserted and gastric suction established. He had vomited at least 1000 cc. in less than 24 hours following admission.

Significance of Abnormal Findings

A *blood sugar* above 120 mg. per cent indicates that the glucose that is absorbed from the gastrointestinal tract has accumulated in the circulating blood due to a lack of insulin instead of being stored or used.

Carbon dioxide combining power is a determination of the amount of carbon dioxide which the blood serum

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can hold in chemical combination. It is used to detect acidosis or alkalosis and to determine the degree. Below normal indicates acidosis, above indicates alkalosis.

Sedimentation rate is the speed at which erythrocytes settle when an anticoagulant is added to blood. An increased sedimentation rate indicates the presence of infection but is also present in cancer, liver disease, or pregnancy.

Blood electrolytes — A decrease in positive (alkaline) electrolytes indicates that the patient is in a state of acidosis.

Urine-Clinitest measures the amount of glucose in the urine. Any result higher than negative indicates that there is such an excess of sugar in the circulating blood that it has reached the renal threshold and overflowed into the urine.

Acetest is a test for acetone in the urine. Acetone is produced when the fats are not properly oxidized due to inability to utilize glucose in the blood.

Treatment

To combat dehydration, fluids were given intravenously because of the patient's nausea. He received a total of 5000 cc. of intravenous fluids in the first 24 hours of hospitalization — 3000 cc. of two-thirds dextrose solution in one-third normal saline and 2000 cc. of normal saline. The saline solution was given to help overcome dehydration and to replace the sodium chloride lost by the body when it united with the ketone bodies. It also helped to correct the overacidity of the blood and the urine.

According to the laboratory reports the body electrolytes were still slightly imbalanced the day following the ad-

Laboratory Tests

	Tests taken	*Normal*	*Result*
1st Day	Blood sugar	70-120 mg.%	185 mg.%
	CO_2 combining power	28 m. eq./1.	29.1 m. eq./1.
	Clinitest	negative	1+
	Acetest	negative	moderately positive
2nd Day	White blood cell count	4,500 to 11,500 per cu. mm.	8,100/cu.mm.
	Hemoglobin	14 to 18 gm/100 cc.	15.7 gm/100 cc.
	Sedimentation rate	up to 10 mm. per hr.	14 mm./hr.
	Clinitest	negative	Ranging from 4+to negative
	Acetone test	negative	strongly positive (3 times) moderate (twice)
	Urine-protein	negative	negative
	-glucose	negative	3+
	-acetone	negative	moderately positive
3rd Day	Blood electrolytes:		
	chlorine	103 m.eq./1.	94 m.eq./1.
	bicarbonate	26 "	29.8 "
	sodium	138 "	137.5 "
	potassium	5 "	3.4 "
	Non protein nitrogen	25-45 mg.%	40 mg.%
	Clinitest	negative	ranging from 2+ to negative to 4+
	Acetest	negative	ranging from a trace to strongly positive
4th Day	Clinitest	negative	4+ (4 times)
	Acetest	negative	Ranging from a trace to negative
5th Day	Clinitest	negative	Ranging from 4+ to 1+
	Acetest	negative	Ranging from a trace to negative
6th Day	Clinitest	negative	negative
	Acetest	negative	negative

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ministration of normal saline but Mr. Hood appeared stronger and more alert. His face was no longer flushed. The degree of acetone in the urine was decreased. Wangensteen suction helped to prevent fatigue from frequent vomiting.

Medications

Insulin: Toronto Zinc Insulin was administered — the dosage being estimated according to the degree of glycosuria. Insulin reverses the fat metabolism and establishes carbohydrate metabolism. The maximum effect of this type of insulin takes place two to three hours after administration and its duration of effect is from 4-12 hours, depending on the dosage. It should be administered 15-20 minutes before breakfast because of its rapid action. Toronto, or plain insulin is especially useful in the care of the patient who shows or is expected to show an allergic reaction to insulin. Because of its purity such allergic reactions are avoided or the severity of the reaction is minimized.

During Mr. Hood's first 24 hours in hospital glycosuria was very pronounced. The next day readings were low to negative but on the third and fourth days the sugar content was high again. On the day of discharge, the urine was negative for sugar. The type of insulin was changed to N.P.H. insulin, 40 units once daily.

N.P.H. insulin is a preparation of the antidiabetic principle of the pancreas combined with protamine to form crystals containing insulin, protamine, and zinc. It is a cloudy suspension and must be gently rolled between the hands to mix it thoroughly before administration. Its action is not as prompt as plain insulin but lasts from 28-30 hours. Its greatest effect is achieved in from five to eight hours. The use of N.P.H. insulin is not recommended in complications of diabetes.

Penicillin: Mr. Hood received 600,000 units intramuscularly, twice daily of a combination of two antibiotics: S.R. Penicillin and Dihydrostreptomycin. It is effective against both Gram-positive and Gram-negative organisms by arresting their growth. The average dose is 300,000 units daily. This medication was given to prevent infection in the cut on Mr. Hood's finger. Diabetic patients are more prone than the normal person to infection and once infection occurs a lengthy treatment period is needed to heal the wound. When the doctor removed the splint and changed the dressing on his finger there was no visible sign of infection present.

Largactil exerts a quieting effect on disturbed, overactive, and excited patients by its effect on the autonomic and the central nervous systems. It is also effective in controlling nausea and vomiting through its action on the vomiting mechanism in the medulla of the brain. Mr. Hood was given 25 mgm. on admission after which the drug was administered t.i.d., intramuscularly at first, then orally. For him, its purpose was twofold in that it acted as a sedative as well as an antiemetic.

Stemetil: On the second day Largactil was replaced by Stemetil 10 mgm. t.i.d. orally or intramuscularly. Mr. Hood usually managed to retain the oral dose.

Stemetil is a potent antiemetic. It exerts a rapid and intensive action, free from drowsiness and depressing effects. It is generally well-tolerated but must be used with discrimination. Its use is indicated in nausea, vomiting, mild or moderate mental and emotional stress. The usual dose is five mgm. three or four times daily. It is contraindicated for comatose cases and for patients suffering from marked depression after the use of central nervous system depressants.

Whitfield's Ointment: This ointment was applied to Mr. Hood's feet at bedtime. It has a mild antiseptic action and is used for treatment of fungus infections of the skin. It contains benzoic acid 12 per cent and salicylic acid 6 per cent.

Infantol: This is a vitamin preparation and was given to build up his health generally.

Nursing Care

The nurse had to be alert for any sign of anuria. In order to compare the amount of urine excreted with the amount of fluid taken, an accurate recording of intake and output was a necessity. This record also showed the amount of fluid lost by emesis.

A urine specimen was obtained promptly after admission and sent to the laboratory for analysis. The nurse carried out immediate Clinitest and

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By Robert A. Lyon, M.D., Professor of Pediatrics, University of Cincinnati; Assistant Medical Director, Cincinnati Children's Hospital; and Elgie M. Wallinger, R.N., B.S., M.A., Director of Nursing, Children's Hospital, Columbus, Ohio. 554 pages, with 156 illustrations. $5.00. *New (5th) Edition!*

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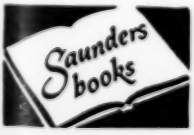
By Sister Charles Marie Frank, C.C.V.I., R.N., M.S.N.E., A Sister of Charity of the Incarnate Word, San Antonio; Dean of the School of Nursing, The Catholic University of America. 304 pages, illustrated. $4.50. *New (2nd) Edition!*



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repeated it q. 4 h. during the day to maintain an accurate check on glycosuria. The laboratory was alerted to the fact that blood samples were to be taken to determine the amount of glucose in the blood.

The nurse had to be thoroughly familiar with the signs and symptoms of diabetic coma and insulin shock. Of the intravenous fluids given, 3000 cc. consisted of two-thirds dextrose solution which could readily have caused coma if not counteracted by insulin administered at proper intervals.

Insulin preparations must be properly stored in a cool place. Dosages must be estimated very carefully and given on time. Sites of injection must be rotated to prevent tissue damage and possible abscess formation.

Mr. Hood's nurses had to watch for signs of reaction to other medications such as Largactil, Stemetil, and penicillin. The Wangensteen suction was irrigated with a small amount of warm water at least q. 4 h. to keep it free from obstruction. The amount and appearance of the return flow was recorded regularly.

Because Mr. Hood became irritated rather easily, care was taken to avoid arguments with him. The nurse had to explain everything that was done for him and have a good reason for doing it. He needed reassurance that every member of the staff was confident of her own ability as well as being confident of the doctor's skill and wisdom.

Rehabilitation and Patient Teaching

Because Mr. Hood had been a diabetic for so many years he required less teaching about the nature of his condition, how to give insulin, how to test his urine. He needed to be reminded of the need for good personal hygiene and for reporting illness to the doctor at its onset. He was reminded not to take medications unless they were prescribed by his doctor. The nurses tried to improve his attitude towards social contacts by introducing him to other patients and by encouraging him to talk about other matters than himself. His doctor recommended an appointment with a foot specialist to have a toenail removed that might become infected or gangrenous.

The day before discharge Mr. Hood's diet was regulated so that he could be on a regular regime of activity again. The dietary requirements were determined according to his height, weight, and anticipated activity. The minimum requirement for a working man is 2500 calories. His insulin dosage was adjusted to his caloric intake. Mr. Hood had a healthy attitude toward his condition. He did not appear to classify himself as an invalid but gave the impression of a man who could live normally within the limits of his handicap.

Annual Meeting in Alberta

A record-breaking attendance of 498 delegates attended the 41st annual convention that was held in Banff in May. In the absence of the President, Miss Margaret Street, Miss Jeanie Clark took the chair and read the president's address. Since the theme of the meeting was "Changing Aspects of Nursing," the address opened with mention of a few of the factors that have and may influence nursing care such as national health insurance, progressive care units and home care plans. Miss Street then went on to describe some of the ways in which the Association has cooperated with the CNA in advancing the cause of nursing. In closing, she stressed the value of the new provincial headquarters in providing the physical facilities for the future expansion of the Association's program.

Miss M. Ruth Thompson, chairman of the Nursing Education Committee explained the relationship between the provincial committee and the national committee. As a member of the CNA core committee on nursing education she outlined the following projects of the national committee: a week's workshop in November to compile Canadian criteria for evaluation of schools of nursing, completion of a "Proposed Guide for Curriculum Development," and the formulation

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5th Edition **Bernard - Jensen**

SOCIOLOGY

Revised to bring all the material up-to-date in the light of current social changes and population growth, the 5th edition of SOCIOLOGY presents the sociological aspects of professional nursing and gives a detailed discussion of the changing role of the hospital as a social institution. This is a text for "Sociology" courses in Schools of Professional Nursing; it can be used effectively in Catholic schools without conflicting with Catholic philosophy or doctrine. This new edition includes up-to-date population reports and changes and a new approach to social problems and social planning.

By JESSIE BERNARD, Ph.D., Professor of Sociology, Department of Sociology, The Pennsylvania State College; and DEBORAH MacLURG JENSEN, R.N., M.A., Associate Director, School of Nursing, St. Louis City Hospital, St. Louis, Mo. 1958, 5th edition, 395 pages, 5½" x 8½", 35 figures, 5 charts. Price, $5.00.

New 2nd Edition **Gebhardt - Anderson**

MICROBIOLOGY

This new 2nd edition can provide your students with an understanding of both the basic principles and practical considerations of microbiology — especially as it applies to everyday life. The chapter on classification, microbial physiology and microbial genetics have been completely rewritten. Complete in scope, the text fully develops the historical aspects of the subject and discusses microorganisms from every angle — from classification through their relation to sanitation and public health. The material on viruses is particularly authoritative and up-to-date since Dr. Gebhardt is a virologist. Theoretical problems relating to the use of antibiotics are also included. The nomenclature agrees with the 7th edition of Bergey's Manual of Determinative Bacteriology.

By LOUIS P. GEBHARDT, Ph.D., M.D., Professor and Head, Department of Bacteriology, College of Medicine, University of Utah, Salt Lake City, Utah; and DEAN A. ANDERSON, Ph.D., M.S., Professor of Microbiology; Head, Department of Biological Sciences, Los Angeles State College of Applied Arts and Sciences, Los Angeles, Calif., New. 1959, 2nd edition, 476 pages, 5½" x 8½", 69 illustrations. Price, $5.75.

2nd Edition **Gebhardt - Anderson**

LABORATORY INSTRUCTIONS IN MICROBIOLOGY

Designed for use with the text described above and three other commonly used textbooks, this lab manual contains 68 clearly written exercises that stress previously observed and practical applications of microbiology to demonstrate basic principles. This revision makes use not only of pure cultures but also of microorganisms in the students' environment — thus stimulating student interest. The manual is divided into seven sections: Basic Principles and Techniques; Physiological Activities; The Effect of Physical and Chemical Agents on Microorganisms; Reactions Involving Antibodies in Serum; Sanitary, Milk and Food Microbiology; Microorganisms in the Soil; and Medical Aspects (Pathogenic Microorganisms). New exercises, line drawings and a simple illustrated key for the identification of common molds have been added as well as demonstrations of newer techniques, equipment and media.

By LOUIS P. GEBHARDT, Ph.D., M.D., Professor and Head of the Department of Bacteriology, College of Medicine, University of Utah, Salt Lake City, Utah; and DEAN A. ANDERSON, M.S., Ph.D., Professor of Microbiology and Head of the Department of Biological Sciences, Los Angeles State College of Applied Arts and Sciences, Los Angeles, Calif. 1958, 2nd edition, 261 pages, 7¾" x 10½", 15 figures. Price, $3.75.

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of a check list for circulation to schools of nursing to ascertain the availability of, or lack of, qualified personnel in schools of nursing in Canada. Miss Thompson reported that the "Suggestions" for regulations covering schools of nursing in Alberta are being re-edited and will be considered by the University of Alberta committee on nursing at their meeting. In closing Miss Thompson noted the very creditable standing obtained by Alberta candidates in the 1958 Registered Nurse examinations.

One of the highlights of the convention was an interesting and stimulating paper on "Preparing for Disaster in the Community and Hospital" given by Miss Evelyn Pepper, Nursing Consultant, Civil Defense Health Services, Department of National Health and Welfare. Miss Pepper outlined types of disasters and types of communities and discussed ways and means of meeting the problems through the community and the hospital.

Dr. S. Greenhill, Associate Professor, Department of Preventative Medicine, University of Alberta, spoke on "Our Changing Society." The first change that he mentioned was in the actual population — in number, age distribution, and area distribution. Linked closely to population change is life expectancy and its effect on our society. Dr. Greenhill continued with a discussion of the changes in medical practice and nursing that have occurred as a result of these factors. He mentioned urbanization, growth of hospitals, medical and nursing specialization, and the effect of the latter on the patient.

The Student Nurses' Association of Alberta was active and presented three important resolutions: that the project of providing information regarding opportunities in nursing, advanced educational programs, and financial assistance available, be referred to the Registered Nurses' Activities Committee of the SNAA; that the SNAA go on record as approving senior matriculation as the minimum pre-entrance requirements for admission to a school of nursing in Alberta: that a) some provision be made in each school of nursing in Alberta to allow for spiritual growth of the student nurse and b) that the philosophies of the various religions be included in the students' educational program. The last resolution was referred back to SNAA executive for further study.

On the fourth day of the convention Miss Lillian Campion, of the CNA National Office, presented a paper on the "International Conference on Conditions of Work and Employment of Nurses." Later, she dis-

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

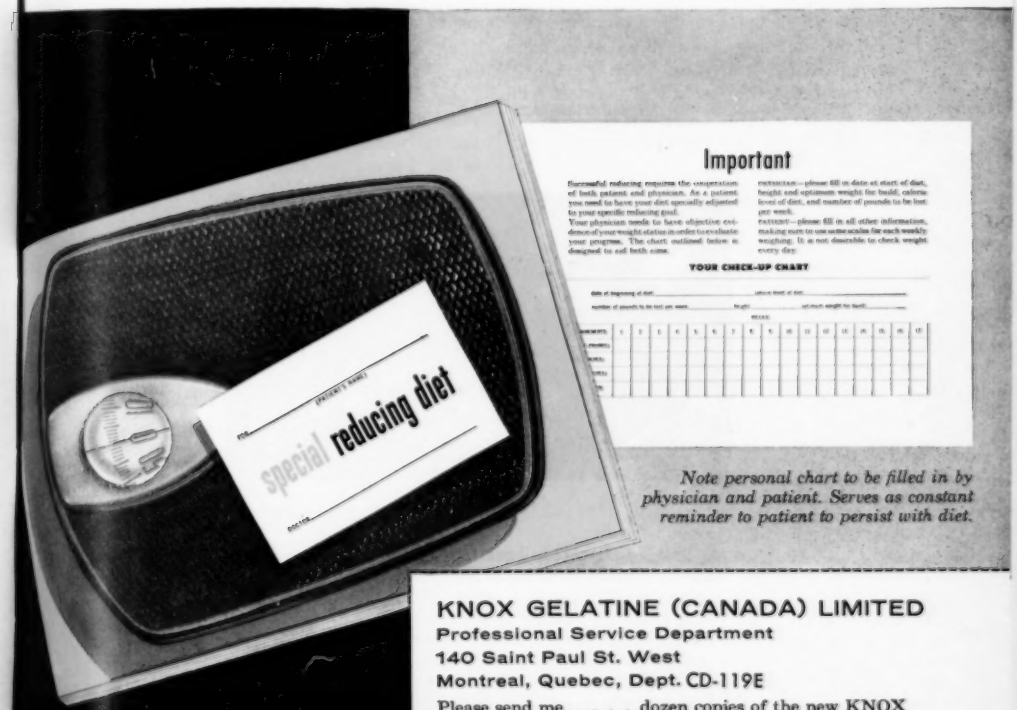
cussed the CNA Retirement Plan, pointing up recent changes in the master plan. The afternoon was given over to a symposium on "What's New in O.R. Technique." Various aspects were covered and included "Principles and Methods of Sterilization," "Protection of Patients and Operating Room Personnel," "Prevention of Staphylococcal Infection," and programs for orientation, in-service training and student nurses. The texts of these papers and two on open heart surgery, as well as other papers presented at the convention, have been published in the August, 1959 issue of the *AARN News Letter*.

CLARA VAN DUSEN
Executive Director

Book Reviews

Small Patients by Alton Goldbloom, M.D., 316 pages. Longmans Green and Company, Toronto. 1959.

In this book a world-famous Canadian pediatrician tells his own life story and, to a certain extent, the story of pediatrics. The facts are simply but most entertainingly presented. There is warmth, humor and understanding of the circumstances that, on various occasions, made the path to eminence slightly thorny. Pediatrics and pediatricians are such a familiar part of the Canadian medical picture that it is a shock to find that as recently as 1920 when Dr. Goldbloom came to Montreal to set up practice the atmosphere was "not overly friendly to pediatricians so far as the medical profession was concerned" and "we (the pediatricians) were clearly not wanted by the group that controlled the destinies of the medical school." Happily, the situation changed so radically over the succeeding 40 years that



Note personal chart to be filled in by physician and patient. Serves as constant reminder to patient to persist with diet.

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the author now is an Emeritus Professor of the university where an influential opponent on the medical faculty had once declared that a Department of Pediatrics would be established only "over my dead body" — a prophetic statement since that was substantially what actually did occur.

Dr. Goldbloom's name is so closely woven into the fabric of the development of pediatric services in this country, that one tends to picture a small boy growing up with an urgent desire to be a doctor. We are quite unprepared to meet instead, the small boy who, at 11 years of age, recited Patrick Henry's speech one Memorial Day in Worcester, Mass. with such fervor that his whole body shook as he thundered the words "But as for me, give me liberty, or give me death!" and who showed much greater inclination for the theatrical rather than for the medical field. We are equally unprepared for the young man of eighteen — uncertain, career undetermined, education unfinished — who finally yielded to his father's urging to go back to university and prepare for the medical field.

Nurses, doctors and the lay public could read this story with equal pleasure. To those in the medical profession, there is much of historical interest. To those acquainted with the author, it is an opportunity to know Dr. Goldbloom in other than a professional way.

Textbook of Anatomy and Physiology by Catherine Parker Anthony, R.N., B.A., M.S. 574 pages. The C. V. Mosby Company, St. Louis. 5th ed. 1959. Price $5.35.

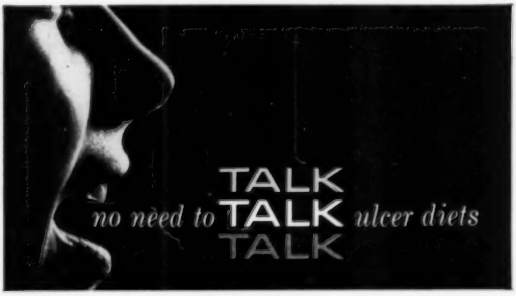
The objectives of this text are to present the basic facts of body structure and function so as to make the teaching of them less laborious, the learning of them less difficult and both the teaching and learning more exhilarating.

Two new chapters have been added to this edition. These are Electrolyte and Fluid Balance and Acid-Base Balance; these are needed. The topics are well explained. Whether they are incorporated into the chapter on the Circulatory System is left to the discretion of the teacher; it seems they might better have been included as part of it.

Most of the diagrams from earlier editions remain; a few have been added, as well as a transparency of the anatomy of the torso.

The chapter on endocrines once again, includes a discussion of some length of diseases of malfunction. Although the students find this fascinating, their interest is turned from physiology to pathology too early and the teacher must spend time giving answers to questions that would have more meaning later in the course of study.

As in earlier editions there is one main problem for both teacher and learner. In the early chapters, functions and structure of the human anatomy are mentionned be-



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Modern management of gastritis, hyperacidity and peptic ulcer[1] continues to stress the valuable role of bland diets in these conditions. You can save considerable time and avoid tiresome repetition by suggesting the new Knox Bland Diets Brochure. Based on a recent review of the literature, **BLAND DIETS in Gastritis and Peptic Ulcer** presents basic facts patients need to know about bland foods, frequent feedings and high protein diet. Easily individualized, this new Knox Brochure enables the ambulatory, unhospitalized patient to progress from a soft bland diet to a permanent bland diet via four specific menus.

1. Kirsner, J. B.: J.A.M.A. 166:1727, (April 5) 1958.

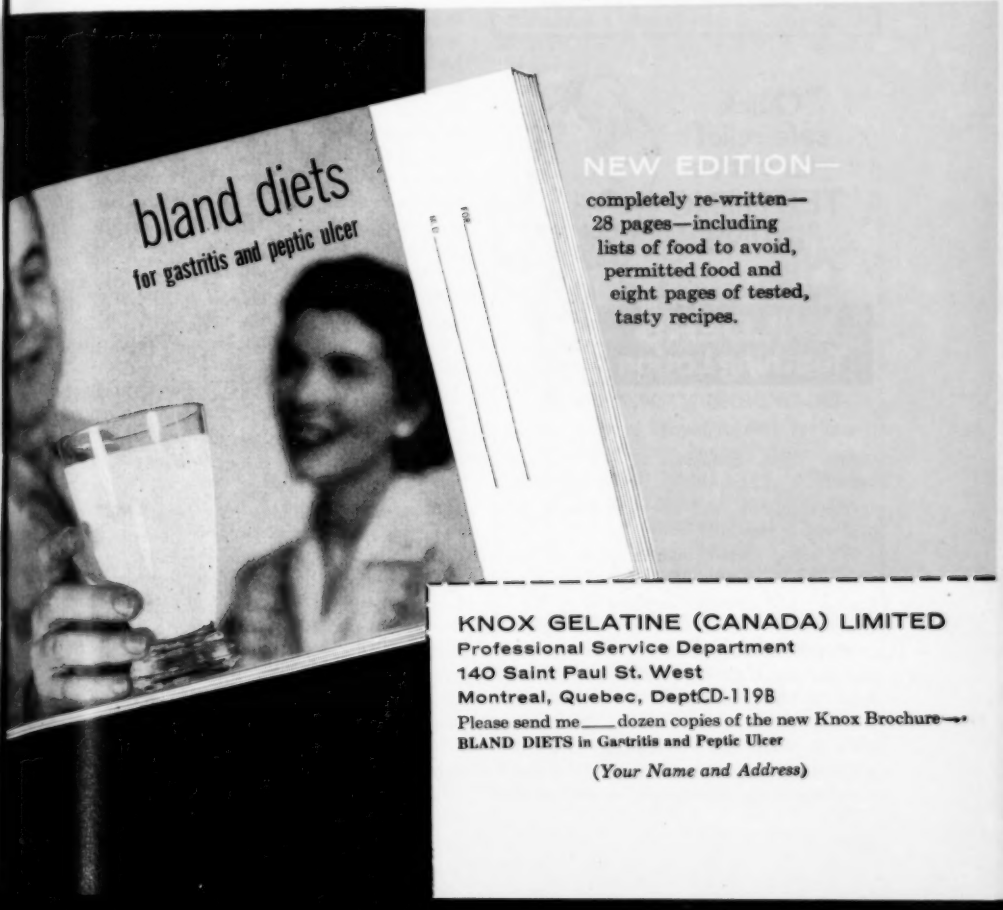
fore they have been explained. As the student has not acquired comprehension of these at this stage it is necessary for the teacher to refer her to later chapters for explanation. If students are expected to read a section of the text before presentation in class by the teacher, this is most inconvenient. This problem is a difficult one for an author to overcome because of the interrelatedness and interdependency of the various parts and functions of the body. Where avoidance of mention of some function that is later discussed is impossible, a simple explanation needs to be made.

Because of this difficulty, where the students are concerned particularly, this book is not recommended as a text for them. Teachers will find it useful for preparation of material, especially teachers of related subjects. For students beyond the junior level and graduates, for purposes of review and reference, the content is excellent.

From Witchcraft to World Health
by S. Leff, M.D., D.P.H. and Vera Leff. 236 pages. Brett-Macmillan Ltd., 132 Water Street S., Galt, Ont. 1958. Price $4.50.
Reviewed by Mrs. N. Anshell, physiotherapist-in-charge, St. Mary's Hospital, Montreal.

This book tells the ever-fascinating story of man's unrelenting fight against disease. The first constitution of the World Health Organization states that "health is a state of physical, mental and social well-being and not merely the absence of disease and infirmity." True to this definition the authors take us through the ages from prehistory to our own time, casting a light on all the factors constituting health and interrelating them closely.

The objective of the book is to give a concise description of how men lived in different periods, what illnesses they suffered from and the methods they employed to



THE ART AND SCIENCE OF NURSING

By Ella L. Rothweiler and Jean Martin White, revised by Doris A. Geitgey. New sixth edition, almost entirely re-written. For student nurse and instructor. Will help in planning a teaching program. 601 pages, illustrated, 1959. $6.50.

PERSONAL, IMPERSONAL, AND INTERPERSONAL RELATIONS

By Genevieve Burton, University of Pennsylvania. A book to develop simple counselling skills and make nurses more able to help their patients. 240 pages, 1958, $3.25.

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combat them. Emphasis is placed on the immediate relationship between the specific development of medicine and the general progress of mankind.

We see primitive man engaged in magic rituals to ward off evil demons that caused disease. We become acquainted with the attempts at rational thought of Egyptian priest-physicians, the first rules of social hygiene laid down by the Jews of Biblical times and the beginnings of medical ethics that originated in Babylon. Continuing through antiquity Greece arises with three schools of medicine — the philosophical, Aesculapian and Hippocratic — only to yield the leadership to Rome whose contribution in the field of healing was born out of its own necessities, conditioned by expanding trade and military campaigns.

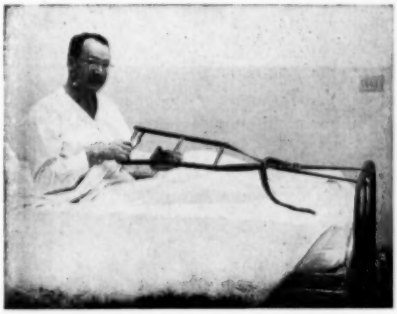
The endless struggle against epidemics and pestilence during the Middle Ages; the attempts of the Church to organize institutions for the sick and poor; the Renaissance with its advances in the study of anatomy and improvements in surgery are described vividly. It is with great interest that we follow the authors into the Age of Enlightenment. The 19th century opens new horizons in medicine, both in recognition of disease and in new devices for fighting it. The discovery of the microscope, electricity and radioactivity as well as the recognition of the cell as a common factor of life revolutionize all preconceived concepts and prepare favorable conditions for man to continue the campaign against ill health into our own time.

It is a far cry from the strangely masked witch doctor to modern ideas of preventive medicine; from the tent on a Roman battlefield where wounded soldiers were assembled, to the bustling, antiseptic activities of our hospitals; from the Victorian nurse of whom Dickens said that "it was difficult to enjoy her society without becoming conscious of a smell of spirits" to the white, crisp sobriety of women attending the sick today. These gaps are bridged in an informative, descriptive way, bringing out the highlights of various periods and weaving them into a comprehensive pattern. It is to be regretted that this inexhaustible subject, at times, is not elaborated in more detail.

Not being a mere record of famous names and important discoveries, but rather emphasizing the conditions which created them, "From Witchcraft to World Health" is easy, lively reading which can be of interest and benefit to layman and medical personnel alike. In a postscript the authors glance into the future, outlining the problems arising from our present way of life and the possibilities for medical skill to create "a world of healthy, happy people at peace."

The inclusion of antibiotics in cosmetics is opposed in a report of the American Medical Association. There is no evidence that "constant degerming" of the skin, such as would be presumed to occur with the use of antibiotics in cosmetics, is "necessarily always or even frequently desirable."

Antibiotics are now being used in deodorants to help kill bacteria and thus reduce odor. They have also been suggested for in-



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clusion in face creams and blemish lotions.

"The persistent trend toward the incorporation of pharmacologically active ingredients into cosmetics has caused growing concern among the medical profession . . . Medical experience provides considerable evidence of the health implications in the widespread, prolonged or indiscriminate use of antibiotics."

There is essential agreement that antibiotics generally useful in the treatment of *systemic* infections should not be used in cosmetics. However, it has been proposed that certain other antibiotics (bacitracin, neomycin, polymyxin and tyrothricin) be permitted in cosmetic preparations.

Even these, which are rarely used other than on the skin, carry certain dangers, according to the report. Some persons may be sensitive to the drugs and develop allergic reactions from continued contact. In addition, little information is available about the possibly harmful effects of the various antibiotics after absorption through the skin.

The possibility of bacteria becoming resistant to the effects of the antibiotics may be increased through prolonged use of the drugs. This would mean that, when the drugs must be used to treat a disease caused by a resistant strain of bacteria, they would be ineffective.

In conclusion, the report said: "Except for the deodorant action of such agents in reducing axillary odors, their incorporation in cosmetics has not been proved to be of specific value, and their widespread use in cosmetics could well represent an increased risk to general public health as well as to certain hypersensitive individuals."

— *The Health Bulletin*, North Carolina State Board of Health.

* * *

Newspapers always excite curiosity. No one ever lays one down without a feeling of disappointment.

— CHARLES LAMB

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Highway Deaths

Motor vehicle accidents in the United States took more lives in each of the first six months of 1959 than in the like months of last year. Through June of the current year, motor vehicle accident fatalities totaled about 17,100, or 5 per cent above the toll a year ago, according to estimates by the National Safety Council.

The increase in motor vehicle accident deaths so far this year parallels the rise in the volume of travel. Consequently, the mortality rate on a mileage basis remained at the record low established a year ago, namely, 5.1 per 100 million vehicle miles. This statistical fact, needless to say, gives little consolation to the many thousands of bereaved families.

Intensified efforts are needed to curb the large and increasing loss of life in motor vehicle accidents. The extent to which such efforts succeed will depend in appreciable part on the progress made in reducing the mortality resulting from collisions of various kinds. Collisions between motor vehicles outranked every other type of accident. In 1957, there were almost 12,000 fatalities in such mishaps. Pedestrians hit by a motor vehicle comprised one-fifth of the victims or close to 8,000. Collisions of motor vehicles with fixed objects, such as trees or poles, were responsible for nearly 2,000 deaths in the year, and collisions with railway trains for an additional 1,400. Most of the deaths in the residual category "other collisions" represent male bicycle riders hit by motor vehicles. Over 7,500 motor vehicle deaths resulted from running off the roadway. Overturning on the road, while of lesser numerical importance, nevertheless took about 1,300 lives. Motorcycle accidents, other than those involving pedestrians, caused nearly 800 deaths in the year, more than 90 per cent of them among males.

Another aspect of the motor vehicle accident problem which merits attention is the relative number of people fatally injured by the various types of vehicles. Approximately 80 per cent of the victims lost their lives in accidents involving passenger vehicles only. An additional 10 per cent of the fatalities resulted from the collision of passenger cars and transport vehicles (mainly trucks, but also such vehicles as tractor trailers, and construction or farm machinery in transport under their own power on the highway). In nearly the same proportion of deaths, transport vehicles only were involved. Buses accounted for only about 1 per cent of the total motor vehicle accident mortality.

The complexity of the motor vehicle problem requires an attack on many fronts. Law enforcement agencies, engineers, educators, and others actively engaged in the safety movement still face a formidable task in reducing the slaughter on our streets and highways. But their efforts will accomplish little if they do not have the wholehearted cooperation of all the people.

— *Statistical Bulletin*
Metropolitan Life Insurance Co.

A new booklet entitled "How to Process and Care for Surgical Gloves" has just been published by Rotary Hospital Equipment Corp. With a suggested work flow layout of equipment, ten basic steps in surgical gloves processing are discussed in detail: Gathering, washing and rinsing, wringing, drying, inspecting, mending, powdering, packaging, sterilizing, storing.

The introduction of mechanical washing, drying and powdering equipment into the surgical glove processing department is fully described with an annual cost analysis for 100 and 300-bed hospitals.

Copies of the booklet as well as illustrated literature covering Rotary Glove Washers, Dryers and Powderers can be obtained, without charge, by writing to Rotary Hospital Equipment Corp., 1746 Dale Road, Buffalo 25, New York.

* * *

The four leading causes of infant death in British Columbia in 1957 were: prematurity 245, postnatal asphyxia and atelectasis 151, pneumonia 141, and congenital malformations 136.

— Vital Statistics, B.C., 1957

* * *

To laugh at men of sense is the privilege of fools. — JEAN DE LA BRUYÈRE

* * *

In the case of news we should always wait for the sacrament of confirmation. — VOLTAIRE

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Registered Nurses or Graduate Nurses (2) for General Duty in 16-bed hospital. Salary schedule according to the current A.A.R.N. suggested schedule. Basic salary $255 for R.N. plus increment increases according to experience. Hospital is centrally located between two (2) lake resorts etc. Apply to: Mrs. J. Bergquist R.N., Matron, Municipal Hospital no. 43, Bentley, Alberta.

General Duty Nurses (2) for 32-bed hospital opened 1-yr. ago. Situated in a town at the crossroads of all main tourist attractions. 32-mi. from the nearest city. Basic salary $270 with regular 6-mo. increases of $5.00 to a maximum of $300, benefits for up to 18-mo. experience. 40-hr. wk., sick time accumulative to 120-days & other fringe benefits, rotating shifts, night duty bonus. Apply: Matron, Macleod Municipal Hospital, Fort Macleod, Alberta.

General Duty Nurses (2) for modern 34-bed hospital. Salary $230 per mo. plus full maintenance, 3 annual increments at $10 per mo., 1-mo. per year holiday pay, 2-wk. sick leave. If employed for 1-yr. a refund of train fare from any point in Canada will be given. Apply to: Municipal Hospital, Two Hills, Alberta, Phone 335.

Graduate Nurses for General Duty in new 30-bed hospital 90-mi. from Calgary on Trans Canada Highway. 44-hr. wk., generous personnel policies. For particulars apply to: The Matron, Municipal Hospital, Bassano, Alberta.

General Staff Nurses (immediately) for new modern hospital of 243-beds, 37-bassinettes. School of nursing has a present enrollment of 58 students. Temporary residence available in new nurses' home. 40-hr. wk., with liberal personnel policies. Apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

BRITISH COLUMBIA

Operating Room Supervisor for modern 154-bed General Hospital. Please reply stating age, qualifications & experience. Salary based on above. **General Duty Nurses.** Generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

Nursing Supervisor (B.C. Registered) for new 26-bed General Hospital opening January 1960. Starting salary $335 per mo. Consideration given in deciding salary to past experience & postgraduate courses. Full maintenance $48 per mo. in new modern nurses' home. Scenic location, excellent working conditions, friendly surroundings, for full particulars write: C. F. Collins, Secretary, Golden & District General Hospital, Golden, British Columbia.

Laboratory Technician (1) Graduate Nurses (3) for 41-bed hospital. Starting salary for R.N.'s, $265 per mo., $255 till registered. 40-hr. wk., 10 statutory holidays, 28 days paid vacation after 1-yr. service, 1½-day sick leave per mo., uniforms laundered. Apply: Sister Superior, Providence Hospital, Fort St. John, British Columbia.

Head Nurses for Operating Room: 42-bed pediatric unit in 434-bed hospital with nurses' training school. Postgraduate or equivalent experience required, B.C. registration required; 40-hr. wk., statutory holidays, 28-days annual vacation. Credit given for past experience & postgraduate preparation. Salary $295-$354. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Registered Nurses (3) for 30-bed hospital in Central B.C. on the Jasper-Prince Rupert Highway, 70-mi from Prince George. Salary $290 per mo., 10 legal days with pay per year; 1½-days sick leave per mo., 28-days vacation after 1-yr. Laundering of uniforms by hospital; modern nurses' residence $50 per mo. Also **Certified Practical Nurses (3)** salary $190 per mo., 1½-days sick leave per mo. 10 legal days with pay per year; 2-wk. vacation after 1-year. Kindly apply giving qualifications & references to: Sister Superior St. John Hospital, Vanderhoof, British Columbia.

Registered General Duty Nurse for 30-bed hospital. Starting salary $270 per mo. with $10 yearly increment. Board & room $40, 1½ day sick leave per mo. 40-hr. wk., 11 statutory holidays & 28 days vacation after 1-yr. service. Comfortable nurses' residence next door to hospital. Rotating shifts. Please apply to: The Matron, Community Hospital, Grand Forks, British Columbia.

General Duty Nurses for small active hospital. Salary $250 for unregistered. $260 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses (all floors). **Operating Room Nurse** (1—experienced for new 125-bed hospital to be opened early in autumn. Commencing salary: $280 per mo. or $294 for 2-yr. satisfactory experience, plus $10 per mo. additional for postgraduate certificate in any of the nursing fields. Supervisory Positions available, salary $315-$378. For further information write to: Director of Nursing, Prince George & District Hosp., Prince George, B.C.

General Duty Nurses for 110-bed General Hospital located in British Columbia's beautiful Northwest. Salary $283 per mo. with $10 increments for 3 years. Modern residence facilities available. For complete information apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurses: starting salary $288 if 2 yr. experience, $275-$330 in 4 yr. Non registered $260. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation, 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $280-$336. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for general duty (2) for 27-bed Community Hospital. Salary: $280 per mo. with 3 annual increments of $10 per mo. Room, board & laundry $40. 28-days vacation after 1-yr. service. Graduate complement 6. Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

Graduate Nurses for 25-bed hospital, 35-mi. from Vancouver on the coast. For salary rates & personnel policies, apply to: Director of Nursing, Squamish General Hospital, Squamish, British Columbia.

Operating Room Nurses with postgraduate training & **General Duty Nurses** for 450-bed hospital. B.C. registration required, salary & personnel policies in accordance with R.N.A.B.C. Apply: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia.

Registered Nurse for new 26-bed General Hospital in the Fraser Valley, 100-mi. from Vancouver. Accommodation available in new residence. Apply: Director of Nurses, Fraser Canyon Hospital, Hope, British Columbia.

MANITOBA

Registered Nurse (for general floor duty). Salary $290 per mo. less $25 for full maintenance, yearly increments, 44-hr. wk. For further information apply to: John Hiscock, Secretary-Treasurer, Baldur Medical Nursing Unit, Baldur, Manitoba.

Registered Nurse (1—Immediately) for 11-bed hospital. Salary: $300 per mo. with increments, less $25 per mo. full maintenance, living quarters in hospital. Please apply to: Birch River Hospital Unit, Birch River, Manitoba.

Registered Nurse (1) Licensed Practical Nurse (1) for 30-bed hospital. Salary $270 & $195 per mo., respectively with $5.00 increases every 6-mo. Excellent working conditions; 40-hr. wk., overtime pay; living quarters. Apply stating age & qualifications to: Mrs. R. Maiers, Superintendent, District Hospital, Roblin, Manitoba. or phone 180 collect.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.

General Duty Nurse for 18-bed hospital, 70-mi. from Winnipeg, daily bus service. Salary $290 per mo. For Personnel policies write or phone: Vita No. 1, The Governing Board, Vita Hospital District No. 28, Vita, Manitoba.

NOVA SCOTIA

General Duty Nurses (4) Operating Room Nurse (1) for well equipped modern 20-bed hospital on scenic Eastern Shore of Nova Scotia's mainland. Salary in accordance with scale set by R.N.A.N.S. Contact: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbour, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1-yr Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville N.S.

ONTARIO

Assistant Director of Nurses, Registered Nurses for General Duty in new 50-bed hospital. Apply: Superintendent, Meaford General Hospital, Meaford, Ontario.

Operating Room Supervisor (Immediately) for 86-bed hospital. Good salary, employee benefits & statutory holidays, living accommodation available in residence. Locate in Collingwood & enjoy its many winter sports along with excellent swimming & other summer activities. Apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Registered Nurse as Superintendent (Immediately) for 30-bed hospital, stating previous experience & salary expected. Furnished 3 room apartment provided. Apply to: Secretary, Englehart & District Hospital Board, Box 609, Englehart, Ontario.

Assistant Superintendent with X-Ray experience for 31-bed General Hospital. Apply: Supt., Louise Marshall Hospital, Mount Forest, Ontario.

Instructor (Qualified) for teaching of psychiatric nursing. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered Nurses (2) for small well equipped hospital, 30 miles from Ottawa. Liberal salary. Apply: Superintendent, The Rosamond Memorial Hospital, Almonte, Ontario.

Registered Nurses for 73-bed General Hospital on Lake of Woods. Tourist & industrial town of 10,000. General duty salary $265-$295 for nurses currently registered; $245 for non-registered qualified nurses. Excellent personnel policies. Apply to: Superintendent, General Hospital, Kenora, Ontario.

Registered Nurses (Several) for immediate & future vacancies in modern 42-bed hospital. Starting salary: $265 per mo. plus shift allowance. 40-hr. wk. 4 wk. vacation after 1 yr. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses for Canadian Army. Officer status. Salary starts $275 - 6-mo. $375 - 3-yr. $409. Regular Staff duties & opportunities for specialization; 30 day leave per year with pay, free medical & dental care; full pay when hospitalized; excellent pension plan for career officers, retirement 45-49. Opportunities for travel. For particulars apply: Army Headquarters, (D Man M2) Ottawa, Ontario.

Registered Nurses for 100-bed active General Hospital in interesting community of 15,000, situated in the beautiful Ottawa valley 2-hrs. from Canada's Capital & 4-hrs. from Montreal, excellent train & bus service, 8-mi. from Camp Petawawa. Membership welcome in curling, bowling, dramatics, ski & golf clubs. Personnel policies include 14 days sick leave, 3-wk. vacation & 7 statutory holidays. Employer participation in pension plan, 5-day wk. At present gross salary $220-$250 with annual increments of $120 up to maximum. Apply to: Director of Nursing, Cottage Hospital, Pembroke, Ontario.

Registered Nurses (Toronto Area) for 30-bed hospital for chronic illnesses. Salary $12 per day; 5-day wk.; 3-wk. vacation per year. Apply: L. Mackie, Director of Nursing, The Villa Private Hospital, Box 490, Thornhill, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $255 & $180 respectively with regular annual increments for both. Excellent personnel policies & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for General Duty. Salary commensurate with experience & qualifications. Apply: Supt., Louise Marshall Hospital, Mount Forest, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience $5.00 increment every 6-mo. 44-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo. 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for Surgical Floor in 163-bed Sanatorium. Excellent personnel policies. Residence accommodation available. Apply: Director of Nursing, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Jamestown, Ontario.

Registered Nurses (2) for General Duty in modern 90-bed hospital, salary $255 per mo. 3 annual increments, accumulative sick leave. Excellent recreational facilities in town near cities & resorts. Room & meals at reasonable rates. Apply: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses for General Duty Staff. Salary $250 per mo., ideal community, winter & summer recreation. Apply to: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary $265 per mo. with annual increments up to $295, 4-wk. vacation with pay after 1-yr. service, 8 statutory holidays, nicely furnished nurses' residence. Apply to: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $260 per mo.** with semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered General Duty Nurses for modern hospital, building expansion under way increasing to 100-beds this year. Starting salary $250 per mo., $215 for Graduates. 40-hr. wk., group life, accident & sickness insurance free to employees. Opportunities for advancement, pleasant community. Apply: Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

Registered General Duty (4) Certified Nursing Assistants (2) replacements for ones who have been married. For 105-bed hospital in a town of 15,000 population. Gross salary ranges from $210-$240 with annual increments. 3-wk. vacation, 7 statutory holidays, Blue Cross medical/surgical participation, 14-day sick leave, no night duty, except in Obstetrical Dept. 8-mi. from Camp Petawawa, 2-hr. from Ottawa & 4-hr. from Montreal with excellent train & bus service. Active, interesting community social life in the heart of the beautiful Ottawa Valley. Active Ski, Curling & Golf Clubs, also the home of the famous Pembroke Lumber Kings Hockey Team. 2 Theatres & a "Drive-In". Forward application to: The Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Registered General Duty Nurses for 28-bed General Hospital. Starting salaries $255-$270 according to qualifications, 40-hr. week, good personnel policies. Adjacent attractive residence available. Room & board $40; recreation facilities. For further information please apply: Miss A. Burnett, Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $250-$260. Good personnel policies with sick leave benefits, holidays & paid vacations. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for 100-bed hospital. Salary $260 per month with recognition for P.G. Courses, 44-hr. wk. at present. Up-to-date facilities in a beautiful location on the shore of Lake Erie. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses (all departments) for 350-bed General Hospital, gross starting salary $255 per mo., 40-hr. wk. Apply to: Director of Nursing, the Doctors Hospital, 45 Brunswick Ave., Toronto, Ontario.

General Duty Nurses for all departments. New 250-bed hospital opening early in 1960 in the Niagara Peninsula. 5-day wk. with 3-wk. annual vacation. Residence accommodation available. Apply: Director of Nursing, Welland County General Hospital, Welland, Ontario.

General Duty Nurses & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Operating Room Nurses (Immediately) for 100-bed General Hospital 25-mi. from Toronto. Good salary, modern residence available. Apply: Director of Nursing, Peel Memorial Hospital, Brampton, Ontario.

General Duty Nurses, Operating Room Nurse (Immediately) for 47-bed hospital, 8-hr. duty, 5½-day wk., annual vacation with pay, statutory holidays, full maintenance in nurses' residence. Apply: Superintendent, General Hospital, Kincardine, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $250 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

Graduate Nurses (Close to Metropolitan Toronto) for 120-active bed County Hospital with up-to-date facilities located in a friendly community, 1-hr. bus ride to downtown Toronto. Salary $245-$285, residence accommodation available. Adequate staffing & personnel policies. Apply: Director of Nursing, York County Hospital, Newmarket, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular neurosurgery, genito-urinary & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Operating Room Nurses for eye, ear, & throat operating room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Operating Room Staff Nurses for modern well equipped department, gross starting salary $255 per mo., rotating hours of duty. Apply to: The Director of Nursing, The Doctors Hospital, 45 Brunswick Ave., Toronto, Ontario.

Public Health Nurse (qualified) for completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurse (Qualified) for generalized program in Etobicoke Township (suburb of Toronto). Minimum salary $3,570, starting salary based on experience. Car allowance $670 per annum. 4-wk. vacation after 1-yr. Pension Plan, P.S.I. & Blue Cross benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Rd., Etobicoke, Ontario.

Public Health Nurses (Qualified) for a generalized program in the City of Oshawa. Salary range $3,500 - $4,370, annual increment $175, starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, City of Oshawa, Ontario.

Graduate Nurses & Certified Nursing Assistants for General Duty complete new 58-bed building with furnishings & equipment. In the heart of summer vacation land. For particulars write to: Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

Director of Nursing for 222-bed new hospital. Position requires Graduate Nurse with teaching & administrative experience. Supervisory experience necessary. Must be available January 1, 1960; applications must be in by November 21, 1959. Reply giving complete qualifications, experience, salary expected & references to: Administrator, Joseph Brant Memorial Hospital, Burlington, Ontario.

Public Health Nurse for generalized public health nursing service; maternal & child health, tuberculosis, school health, etc. Salary $3,500 - $4,500 annually; annual increment $200, hospital plan, P.S.I., pension plan, sick leave — 1½ days per mo., accumulative. 4-wk. vacation yearly. Transportation provided or allowance for use of private car. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ont.

Public Health Nurses (2 - Bilingual) for generalized public health nursing service; maternal & child health, tuberculosis, school health, etc. Salary $3,500 - $4,500 annually; annual increment $200, hospital plan, P.S.I. pension plan, sick leave 1½ days per mo., accumulative. 4-wk. vacation yearly. Transportation provided or allowance for use of private car. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario

QUEBEC

Nursing Superintendent for modern, accredited 60-bed hospital. Living accommodation available. Apply stating qualifications & salary expected to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Assistant Head Nurses; Afternoon Supervisor excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses & Operating Room Supervisor for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $250 per mo., $5.00 increase every 6-mo. for 5 increases. Monthly bonus for permanent evening & night shifts. 44-hr. wk. Board & accommodation available in new motel-style nurses' residence. Apply: Supt., Barrie Memorial Hospital, Ormstown, Quebec.

Registered General Duty Nurses for 28-bed General Hospital in Huntingdon, Quebec, 45-mi. from centre of Montreal with excellent bus service. Gross salary $235 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $250; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays; 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., Huntingdon County Hospital, Huntingdon, Que.

BERMUDA

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate courses and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

SASKATCHEWAN

Registered General Duty Nurses for 25-bed hospital in progressive area. Salary $290-$320 per mo. gross, 40-hr. wk. 3-wk., annual vacation, accumulative sick leave. New nurses residence. Apply to: Sec.-Manager, Union Hospital, Leader, Saskatchewan.

U.S.A.

Supervising Nurse $371-$439; **Staff Nurse** $332-$392 for California Hospital treating pulmonary & chronic diseases (rehabilitation), children & adults. Eligible California registration. Excellent working & living conditions, Sierra Nevada foothill area. Write: Director of Nursing, Tulare-Kings Counties Hospital, Springville, California.

Registered Nurses for modern 191-bed JCAH fully accredited General Hospital, expanding to 374-beds by 1960. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director. Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered General Duty Nurses for modern accredited 76-bed hospital (South Central California near Sequoia National Park). Beginning salary: $315 per mo., annual increases. Excellent working conditions. Ideal community. Winter & summer recreation. Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, Exeter, California.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts, evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty; $345 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot road, Castro Valley, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

General Duty Nurses (English Speaking) 500-bed General Hospital in sunny Southern California. $330-$375 base plus $33 shift differential upon registration. **Operating & Delivery Room Nurses** $340-$385 upon registration plus $33 shift differential. Employee health & pension plan. Generous holiday & vacation benefits. Nurses' residence. Apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

General Duty Nurses for 600-bed teaching hospital in central California. In-service educational program, college community, good fringe benefits. Salary range $341-$413. Apply: Personnel Director, 732 East Main St., Stockton 2, California.

General Duty Nurses for 100-bed County Hospital, accredited JCAH. San Joaquin Valley, 40-hr. wk., liberal sick leave, 3-wk. annual vacation, 12 annual holidays. Starting salary open, range $314-$392, plus $10 shift differential. Rooms in modern nurses' home at $10 per mo. Write, wire or phone: Superintendent of Nurses, County General Hospital, Tulare, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40 hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Staff Nurses positions available in Medical-Surgical & Intensive Care units in modern 238-bed hospital. Starting salary $335 per mo. with tenure increases; differential pay for 3-11 & 11-7 shifts of $15 per mo. Liberal personnel policies, opportunities for advancement, social security, hospitalization insurance provided by hospital. Apply: Director of Nursing, Samuel Merritt Hospital, Oakland 9, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154--bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 400-bed nonsectarian General Hospital affiliated with Medical School. New salary rates: day shift $340-$370 per mo. afternoon & nights $370-$400 per mo. Comfortable low cost living accommodation in attractive residence building Write to: Director of Nursing Service, Dept. CJN, Mount Sinai Hospital, 2750 West 15th Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Registered Nurses: Applicants must speak & write proficient English. Starting salary from $310 per month plus a differential for evening work. Apply to: The Personnel Director, The Gary Methodist Hospital, 1600 W. 6th Avenue, Gary, Indiana.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES

OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic Northwest Territories and the Yukon Territory.

SALARIES

(1) Public Health Nursing Supervisors: up to $5,220 depending upon qualifications and location.

(2) Directors of Nursing in Hospitals: up to $4,950 depending upon qualifications and location.

(3) Public Health Staff Nurses: up to $3,780 per year depending upon qualifications and location.

(4) Hospital Staff Nurses: up to $3,540 per year depending upon qualifications and location.

(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

• Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-medical and superannuation plans available.

• Special pay and leave allowances for those posted to isolated areas.

For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurses: Immediate & future vacancies in expanding hospital in the heart of the Water Wonderland. Starting salary $361 per mo. with automatic pay increases to top salary of $391 per mo., differential for evening & night duty, 40-hr. wk., free laundry service. Nearby university facilities available, liberal personnel policies. Must be willing to rotate shifts. Reply: Director of Nursing Service, General Hospital, Pontiac, Michigan.

General Duty Nurses for 350-bed hospital with NLN accredited school of nursing, 20-min. from downtown Detroit. Starting salary $331, increments at 6 months, 1 year & 2 years, maximum $372. Rotating shifts or permanent afternoon & night shifts. 2-wk. vacation, 18-days sick leave, 6 legal holidays per year with no loss in salary. Liberal hospital, medical, surgical & life insurance benefits. Write: Director of Nursing, General Hospital, Highland Park 3, Michigan.

Registered Nurses (free transportation) Spend your winter in the Sunny Southwest, in New Mexico — "The Land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics & Operating Room. Starting salaries $300 per mo., $15 differential evenings & nights. Free transportation via 1st Class Air to Albuquerque & return in exchange for 1-yr. employment contract. Apartments available at $17 per mo., excellent job benefits, no shift rotation. Write or call: Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone CHapel 3-5611.

Graduate Nurses (Staff & Operating Room) for 88-bed modern accredited General Hospital. Liberal personnel policies, college town 30,000, 85% sunshine belt, altitude 3,860. Dry, mild, all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon

Staff Nurses (all services) for University of Texas Medical Branch, teaching hospital (air conditioned). Good personnel policies. Base salary, rotation: $290 per mo. Evenings or night, $304 per mo. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Registered Nurses (California) for progressive ultra-modern 200-bed hospital (near Beverly Hills), in medical surgical units & operating room. Starting salary $330 per mo. with 6-mo. increase & yearly increases thereafter; 5-day, 40-hr. wk., 8 paid holidays annually, paid vacation, paid sick leave, free hospitalization & life insurance, plus unemployment & disability insurance. Opportunities for advancement & in-service education program. Work in a friendly efficient atmosphere possessing many new time & effort saving devices. Off-duty time may be spent in the sun & social activities of "Southern California Living". Apply Director of Personnel, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48, California.

Staff Nurses for 388-bed approved County Hospital, 100-mi. south of San Francisco. $342-$401 P/M plus differentials, excellent fringes. Temporary permit required. Reply: Joseph J. Wahl, Monterey County Hospital, P.O. Box 1611, Salinas, California.

SASKATCHEWAN

Registered Nurses (Female help) for 82-bed accredited hospital. Salary $255-$295 per mo., 40-hr. wk., no split shifts. Living accommodation in nurses' residence, laundry of uniforms provided for $8.00-$12 per mo., transportation refunded after 6-mo. service. Apply: Superintendent of Nurses, Union Hospital, Canora, Saskatchewan.

General Duty Nurses (2) for modern 22-bed hospital located in a pleasant active community. 40-hr. work wk., basic salary $260 per mo., residence accommodation available at $34.50 per mo. Positions available immediately. Apply to: J.R. Huckstep, Secretary-Manager, Union Hospital, Shellbrook, Saskatchewan.

ENGLAND

Plastic Surgery, Jaw Injuries & Burns Centre, St. Lawrence Hospital, Chepstow, Mon. England. (127-Plastic Surgery, 50-Orthopedic beds). 6-mo. postgraduate course on Plastic Surgery for Canadian trained nurses commences April 1st. Post provides opportunity of gaining further experience & seeing something of England. Full national nurses' salary paid. Good knowledge of English essential & must pay own fare to England. This post provides an opportunity for those who wish to take a working holiday with pay. Write quoting 2 references to T. A. Jones, Group Secretary, 64 Cardiff Road, Newport, Mon. England.

QUEBEC

General Duty Registered Nurses for modern 80-bed hospital, salary $205 per mo. plus meals, laundry & differential pay, rotating shifts, 44-hr. wk., Resident accommodation available. Benefits include 30-days annual vacation, sick leave allowance & B.C. hospitalization paid by hospital. Equally French & English speaking industrial community, 50-mi. south of Montreal, Eastern Townships. Excellent bus & train service. Apply: Director of Nursing, Brome-Missisquoi-Perkins Hospital, Sweetsburg, Quebec.

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requires

NURSING STAFF

Variety of Opportunities, Valuable Experience in this large teaching centre. Attractive Personnel Policies. Five Day Week. The Toronto General Hospital has opened its new building which contains centralized Operating Rooms; Recovery Rooms; Surgical Supply Service; Obstetrics and Gynecology; Neurology and Neurosurgery; Admitting and Emergency; Rehabilitation and Physical Medicine; Urology and Ophthalmology.

For information write to:

Director of Nursing, Toronto General Hospital, Toronto 2, Ontario.

NEW MOUNT SINAI HOSPITAL

Toronto

Modern 400-bed Hospital

requires

REGISTERED NURSES

and

Certified Nursing Assistants

40-hour week - Pension plan

Good Salaries and Personnel Policies

Residence Facilities Available

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NEW MOUNT SINAI HOSPITAL
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TORONTO

THE GENERAL HOSPITAL OF PORT ARTHUR

has openings for

GENERAL STAFF NURSES

in all services

For further information apply to:

DIRECTOR OF NURSING,
GENERAL HOSPITAL,
PORT ARTHUR,
ONTARIO.

— WANTED —
NURSE

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
JORDAN MEMORIAL SANATORIUM
THE GLADES, N.B.

QUALIFICATIONS: Graduation from a recognized school of Nursing. Registration as a Nurse in one of the Provinces of Canada. Supervisory nursing experience.

DUTIES: The duties of this position involve professional nursing work in the Sanatorium and the sharing of supervisory responsibility in the administration of the Nursing Service of the hospital.

SALARY: $3,000 - $3,720 per annum. Annual Increment $180. Salary commensurate with education and experience.

Full Civil Service Benefits including three weeks annual vacation with pay, sick leave benefits, superannuation and retiring leave. Potential opportunity for advancement to the position of Superintendent of Nursing.

Apply:

CIVIL SERVICE COMMISSION, P.O. BOX 1055, FREDERICTON, N.B.

GUELPH GENERAL HOSPITAL
REQUIRES
STAFF FOR THE FOLLOWING POSITIONS:

Assistant Head Nurses — General Wards (3), General Staff Nurses, Certified Nursing Assistants, Active Hospital 200-beds, Pleasant city 36,000 — 3 colleges. Excellent salary & personnel policies, Additional salary for postgraduate study in specialty.

For further information apply to:

DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO.

REGISTERED NURSES
$3,150 - $3,540
(According to Qualifications)

CERTIFIED NURSING ASSISTANTS
$2,040 - $2,400

Sunnybrook Hospital, Toronto, Ont. Westminster Hospital, London, Ont.
Deer Lodge Hospital, Winnipeg, Man.

Pension Plan; 3-wk. paid vacation, 3-wk. accumulative sick leave; 5-day wk.; low-cost living in staff residence — for Nurses. Application forms available at Civil Service Commission Offices, National Employment Offices & main Post Offices should be forwarded to the Civil Service Commission Office in the province where the vacancy in which you are interested exists.

ONTARIO: 25 ST. CLAIR AVENUE EAST, TORONTO - MANITOBA: 266 GRAHAM AVENUE, WINNIPEG

PEDIATRIC SUPERVISOR

for 20-bed Pediatric Unit

DUTIES TO INCLUDE ADMINISTRATION OF THE UNIT AS WELL AS TEACHING OF STUDENT NURSES. ESPECIALLY ATTRACTIVE SALARY OFFERED.

For details apply to: Director of Nursing

GENERAL HOSPITAL, CORNWALL, ONTARIO.

THE WINNIPEG GENERAL HOSPITAL

is recruiting

GENERAL DUTY NURSES FOR ALL SERVICES

Please send applications direct to:

THE DIRECTOR OF NURSING,
THE WINNIPEG GENERAL HOSPITAL,
WINNIPEG 3, MANITOBA

Are you a
General State Registered Nurse?

Do you enjoy
Nursing
which brings you into
Closer Contact
with your
Patients
and their families?

Are you interested in
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Have you some or no experience in
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Do you want a
Short Term Appointment
in a unique & useful sphere?

Have you also read the advertisement under Postgraduate Nursing Education?

Then write, giving particulars of your training, to:—

Matron,
THE NATIONAL HOSPITAL
QUEEN SQUARE,
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GENERAL DUTY NURSES
FOR ALL DEPARTMENTS

Gross salary $255 monthly ($117.50 bi-weekly) if registered in Ontario, $235 monthly (108.20 bi-weekly) until registered. Annual increment $10 monthly ($4.60 bi-weekly) for three (3) years. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12-days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL
REQUIRES

NURSES FOR GENERAL DUTY IN ALL SERVICES.

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

SUBURBAN TORONTO
GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $255-$305 per mo. Certified Nursing Assistants $190-$210 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

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REGISTERED NURSES
FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $260 - $290 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

Residence, Cook County School of Nursing

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COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $340-$372.50 for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

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Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

TWO (2) REGISTERED NURSES

For a new modern, 57-bed hospital. — Salary $260 - $320 per month.

40-hour week, no split shifts, sick leave,
3 weeks vacation plus 8 statutory holidays,
New nurses' residence completed May 1959.
Meals, living accommodation in nurses' residence (single rooms)
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Apply:

MRS. T. WALLACE, SUPERINTENDENT OF NURSES, KAMSACK UNION HOSPITAL, KAMSACK, SASKATCHEWAN.

THE SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL

REQUIRES

HEALTH INSTRUCTOR

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of 2-yr. of nursing education followed by 1-yr. internship. 1 class of 30 students is admitted yearly. Duties include being in charge of student health program and instructing in both classroom and clinical areas. Subjects: Health, Sociology, Microbiology and assist with Medical-Surgical Nursing. Requirements: university certificate in nursing education or public health. Salary differential for degree.

For further information apply to:

DIRECTOR, SCHOOL OF NURSING, 2240 KILDARE ROAD, WINDSOR, ONTARIO.

REGISTERED NURSES
NURSING ASSISTANTS

Required for all departments in new 160-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan, 40-hour week.

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- For Nursing Office
- Interested in Medical and Surgical Supplies
- Opportunity for an executive future in "Extended Illness"
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- Living-in residence optional.

Apply Administrator:

The Queen Elizabeth Hospital,
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WOODSTOCK GENERAL HOSPITAL

Woodstock, Ontario

requires

Registered Nurses
for Operating Room, Obstetrical,
Medical and Surgical units.

For further information write:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
WOODSTOCK, ONTARIO.

NURSING SUPERVISORS

required for

MENTAL HEALTH SERVICES,

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Salary: $324 - $389 per month

Duties are those of nursing supervisors in modern psychiatric & geriatric units.

Applicants must be British Subjects, registered nurses, with training in a mental hospital setting & supervisory experience.

For further information & application forms, apply to:

THE PERSONNEL OFFICER, B.C. CIVIL SERVICE COMMISSION, ESSONDALE, BRITISH COLUMBIA.
IMMEDIATELY. COMPETITION No. 59:152

REGINA GENERAL HOSPITAL

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Requires:

— an Assistant Director, Nursing Education.
— and a Nursing Arts Instructor.
modern teaching facilities and progressive personnel policies.

Apply to:

**ASSOCIATE DIRECTOR, NURSING EDUCATION,
REGINA GENERAL HOSPITAL, SCHOOL OF NURSING,
REGINA, SASKATCHEWAN.**

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

**DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN**

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
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- Vacation with pay.
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For further information write to:

Director in Chief,
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For a School of 90 students, organized independently of Nursing Services. The school program follows the pattern of 2 years of nursing education plus 1 year of internship.

Salary: $5,400-$6,000 per annum.

Requirements: Degree & experience in the administration of a nursing education program.

Apply to: R. Buckner, Administrator,

**Metropolitan General Hospital
Windsor, Ontario**

KINGSTON GENERAL HOSPITAL

KINGSTON, ONTARIO

requires

Head Nurse with special preparation & experience in psychiatric nursing, to take charge of a psychiatric unit at present under construction.

Assistant Head Nurse with similar training, also required.

Salary commensurate with experience & training will be set at time of interview.

Full details relating to hours, vacations & benefits supplied on application to:

DIRECTOR OF NURSING

KINGSTON GENERAL HOSPITAL

KINGSTON, ONTARIO

REQUIRES

GENERAL DUTY NURSES

CERTIFIED NURSING ASSISTANTS

To inaugurate a 40-hour week and staff a new 120-bed wing.

Salary commensurate with preparation & experience.

Apply to:

MISS HAZEL I. MILLER, DIRECTOR OF NURSING

REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, to implement a 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies.

APPLY TO: DIRECTOR OF NURSING, HALDIMAND WAR MEMORIAL HOSPITAL, DUNNVILLE, ONTARIO

NURSES REQUIRED AT

ROSEWAY HOSPITAL, SHELBURNE, N.S.

4 GENERAL DUTY NURSES
(Medical, Surgical, Obstetrical) $2,400 - $2,760

1 NURSING SUPERVISOR
$2,640 - $3,120

2 GRACE HOSPITAL GRADUATES
(Obstetrical) $1,980 - $2,340

Further information may be obtained from Superintendent of Nurses, Roseway Hospital

APPLY TO: NOVA SCOTIA CIVIL SERVICE COMMISSION, P.O. BOX 943, HALIFAX, N.S.

DIRECTOR OF NURSING

Modern hospital 42-adult beds, 11-bassinets, located in a Company operated town & serves a population of approximately 6,000. Salary range from $357 - $477 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

ADMINISTRATOR, ANSON GENERAL HOSPITAL, IROQUOIS FALLS, ONTARIO.

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Up to 6 hours a semester—with full tuition refunded —may be taken at any accredited educational institution in the Baltimore-Washington area by nurses on the staff of the Johns Hopkins Hospital.

Send now for further information about this educational opportunity and for your copy of the 16-page illustrated booklet "Nursing at Johns Hopkins."

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Director of Nursing Service
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Baltimore 5, Maryland

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